‘One Stop Centres’ and State Accountability for Sexual Violence against Women: Comparing Service Integration Models in Kenya and South Africa

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DECLARATION

I, Ruth Nekura Lekakeny, hereby declare that the work on which this thesis is based is my original work (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university. I authorise the University to reproduce for the purpose of research either the whole or any portion of the contents in any manner whatsoever.

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ABSTRACT

There is increasing recognition that sexual violence victims have multiple and complex needs, requiring the joint intervention of multiple sectors to generate a more effective response. As such, multi-sector collaborations that integrate health, legal and psychosocial support services are acknowledged as a best practice intervention. Despite the dearth of evidence on how such integration approaches operate in resource-constrained settings, they continue to be established and scaled up in parts of Africa. Using a qualitative case-study approach, this thesis seeks to understand how integration approaches in Kenya and South Africa contribute to the fulfilment of the human rights obligations of states to prevent and effectively respond to sexual violence against women.

I use interview data to compare Kenya's Gender Based Violence Recovery Centres and South Africa's Thuthuzela Care Centres across rural, peri-urban and urban contexts. The thesis moves away from current analysis approaches, which assess integration models based on separate, sector-specific outcome indicators, such as health or criminal justice system outcomes. I use a feminist human rights perspective, based on the state's responsibility to exercise due diligence in prevention, protection, prosecution, punishment and provision of adequate redress. This perspective facilitates the centrality of victims' needs and rights in assessing service integration models, while foregrounding the need for state accountability to establish sustainable and effective sexual violence interventions.

I argue that multisector approaches that integrate sexual violence services are complex networks, which produce different service orientations, shaped by the interactions of collaborating partners, amidst fundamental systemic and structural flaws. In the governance of collaboration systems, different service orientations emerge as stakeholders within networks, wield their resources, mentalities, methods and institutions to produce certain outcomes as priority over others. Consequently, as competing sector-specific mandates and ideologies are prioritised, multi-sector approaches can eclipse and de-centre the needs and rights of sexual violence victims.

To fulfil the state responsibility to exercise due diligence, there is a need to re-orientate integration models in a way that centres the needs and rights of victims rather than the competing institutional mandates of network players. This requires the implementation of a victim-centred integration approach that goes beyond creating safe havens or protected processes through specializations, to that of shifting deeply-rooted social and institutional norms, which are the root causes of violence against women.

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LIST OF ABBREVIATIONS

CBO	Community Based Organisation
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CREAW	Centre for Rights Education and Awareness
DEVAW	Declaration on the Elimination of all forms of Violence against Women
DoH	Department of Health
DSD	Department of Social Development
GBVRC	Gender Based Violence Recovery Centre
GRC	Gender Recovery Centre
GVRC	Gender Violence Recovery Centre
IJM	International Justice Mission
KNH	Kenyatta National Hospital
MATTSO	Ministerial Advisory Task Team on the Adjudication of Sexual Offence Matters
NGO	Non-Governmental Organisation
NPA	National Prosecuting Authority
OSC	One Stop Centre
OSCC	One Stop Crisis Centre
PEP	Post Exposure Prophylaxis
PRC	Post Rape Care
P3 form	Kenya police medical examination form
SAPS	South African Police Department
SOCA	Sexual Offences and Community Affairs
SRVAW	UN Special Rapporteur on violence against women, its causes and consequences
TCC	Thuthuzela Care Centre

TABLE OF CONTENTS

CHAPTER 1

INTRODUCTION

1.1. Background

Annette,[1] a 26-year-old woman living in a low-income settlement in Nairobi first disclosed her experience of rape to a nurse at a local private hospital, two days after the ordeal. Annette described her experience of receiving services during a group interview I conducted as part of this research, which explores how multi-sector approaches that integrate health, legal and psychosocial services contribute to fulfilling State obligations to address sexual violence.[2] She recounted what this nurse said to her: '…rush to Kenyatta National Hospital (KNH), you've only got a few hours left, make sure you pass through the HIV testing centre, you will be directed what to do'.[3] This private clinic referred Annette to KNH because they did not have emergency medical treatment to prevent sexually transmitted infections or pregnancy.[4]

When Annette arrived at the KNH casualty department, a health worker referred her to the Gender Based Violence Recovery Centre (GBVRC), located within the facility. 'It was difficult to locate this place, but the services were fast. Less than thirty minutes…'[5] she explained. Annette received medical treatment, counselling and was invited to join a victim support group. The GBVRC social worker also assessed Annette's safety circumstances, referred her to a women's shelter and assisted her to inform her family, saying, 'in case we take your daughter to a safe house it is not because of anything bad, it's because we would like to offer her protection.'[6] Despite the best efforts of counsellors, social workers, and health providers at the centre, Annette did not always feel safe. She said:

> I used to feel safe when I have entered this centre, but when I left, and I am alone, I am not safe. Sometimes I see him. I wish the centre could communicate with the chief

[1] Pseudonym used to protect the victim's identity.
[2] Group interview with sexual violence victims supported through Kenyatta National Hospital Gender Based Violence Recovery Centre on 7th June 2016.
[3] Ibid.
[4] Kenya Ministry of Health, *National Guidelines on Management of Sexual Violence in Kenya*, 3 ed. 2014 at 12. These guidelines require provision of emergency contraception and Post Exposure Prophylaxis due to exposure to HIV which has to be started within 72 hours after the sexual violence.
[5] Group interview, above note 2.
[6] Ibid.

> or police near me, it would be nice. Because I can run to that police or chief and say "Oh! I have seen the perpetrator again."[7]

One counsellor informed Annette that if she wanted to report to the police 'they have their own NGO lawyers, and they can step in when it comes to court sessions. That helped me to relax about the issue',[8] she said. When Annette reported to the police, she spent five days moving back and forth from the hospital, the police station and the police surgeon trying to get them to complete the medico-legal forms (P3 form).[9] She was exhausted from having to deal with a different investigating officer each time who 'kept telling me maybe I was drunk'.[10] The last investigating officer 'saw the hospital's report that I had bathed – it was marked with a tick, and said "oh if you bathed, as we can see, then we cannot help you."'[11] After saying these words, Annette paused, sighed heavily, and concluded: 'So, yes, it is not even about this centre, it is the government that should come in to protect us. It should be that if someone has raped another, they are locked away for life'.[12] Annette then looked around the room at the other six participants in the group discussion, who nodded in agreement with her.[13]

1.2. Sexual Violence: Persisting Problems, Integration as the Acclaimed Solution

Sexual violence against women is not a new phenomenon.[14] Despite progress in law reforms that recognise sexual violations as crimes and human rights violations, it remains pervasive. Global studies suggest that sub-Saharan Africa has some of the highest rates of sexual violence against women, estimating that 45.6 per cent of women experience either physical or sexual violence in their lifetime, in comparison to the global average of 35 per cent.[15]

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[7] Ibid.
[8] Ibid.
[9] The Kenya Police Medical Examination form.
[10] Group interview, above note 2.
[11] Ibid.
[12] Ibid.
[13] Field notes from group discussion with sexual violence victims supported through Kenyatta National Hospital Gender Based Violence Recovery Centre on 7th June 2016.
[14] García-Moreno, C., Pallitto, C., Devries, K., *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence* (2013).
[15] Ibid at 20.

There is a general lack of proper statistics of the prevalence of sexual violence in both Kenya and South Africa. Available statistics rely heavily on the number of reported cases, which lead to gross under-estimations because women victims hardly report sexual offences.[16] For example, a survey in South Africa found that only one in 25 women who had ever been raped had reported their experience of rape to the police. [17] Similarly, in Kenya, it is estimated that only 23 per cent of women who experience rape will disclose their experience.[18]

South Africa's police statistics show that 49 660 sexual offences were reported to the police in 2016/2017 year.[19] Other studies in South Africa estimate that up to 55.5 per cent of women have experienced sexual or physical violence by an intimate partner.[20] Studies on rape perpetration in South Africa also show a high prevalence of multiple rapes, with a majority of first rapes being perpetrated by young men before age 20.[21] In Kenya, police statistics do not disaggregate the data of sexual offences reported. Ten years after the Sexual Offences Act was enacted,[22] police statistics still use the repealed and general categories of 'offences against morality' and 'other offences against persons' to report sexual offences.[23] Kenya's

[16] Scholars have considered the various reasons why women do not report. One factor is this regard is the role of informal support and how it leads women to seek formal services. See for example Ullman, S. E., & Filipas, H. H., 'Correlates of formal and informal support seeking in sexual assault victims' (2001) 16(10), *Journal of Interpersonal Violence* 1028. Other authors show that seeking formal services is dependent on whether the rape fits the stereotypical 'real rape' script such as the perpetrator being someone other than the victim's boyfriend. See Rickert, V. I., Wiemann, C. M., & Vaughan, R. D., Disclosure of date/acquaintance rape: Who reports and when. (2005) *18*(1) *Journal of Pediatric and Adolescent Gynecology* 17.; Bachman, R., 'Predicting the reporting of rape victimizations: Have rape reforms made a difference?' (1993) 20(3), *Criminal Justice and Behavior* 254.

[17] Machisa, M., Jewkes, R., Lowe Morna, C. et al., *The War at Home: The Gauteng GBV Indicators Research Study,* 2011.

[18] Tavrow, P., Withers, M., Obbuyi, A. et al., 'Rape myth attitudes in rural Kenya: toward the development of a culturally relevant attitude scale and "blame index"' (2013) 28(10) *Journal of Interpersonal Violence* 2156. Kameri-Mbote argues that statistics on sexual violence in Kenya remain uncertain due to societal pressures and cultural attitudes which impress the importance of chastity and honour, thereby undermining the reporting of sexual violence. Kameri-Mbote, P. *Violence against Women in Kenya: An Analysis of Laws, Policies and Institutions*, 2000.

[19] South Africa Police Service *Crime situation in South Africa 1 April 2016 - 31 March 2017*, 2017.

[20] Dunkle, K. L., Jewkes, R. K., Brown, H. C., et al., 'Prevalence and patterns of gender-based violence and re-victimization among women attending antenatal clinics in Soweto, South Africa' (2004) 160(3) *American Journal of Epidemiology* 230; Abrahams, N., Jewkes, R., Laubscher, R. et al., 'Intimate partner violence: prevalence and risk factors for men in Cape Town, South Africa' (2006) 21(2) *Violence and Victims* 247.

[21] Jewkes, R., Sikweyiya, Y., Morrell, R., et al., 'Gender inequitable masculinity and sexual entitlement in rape perpetration South Africa: findings of a cross-sectional study' 2011 6(12) *PloS One* 14; Jewkes, R., Dunkle, K., Koss, M.P. et al., 'Rape perpetration by young, rural South African men: Prevalence, patterns and risk factors', (2006) 63(11) *Social Science & Medicine* 2949.

[22] The Kenya Sexual Offences Act 3 of 2006.

[23] Kenya National Police Service, *Annual Crime Report*, 2016. The quotations show the precise words used to classify sexual offences in these crime reports

demographic health survey remains the only available source of data, the most recent estimating that 47 per cent of women between the ages of 15 and 49 reported that they have experienced either sexual or physical violence.[24]

Sexual violence victims, like Annette, have multiple and complex needs that vary, based on the circumstances of each individual victim. Some of these basic needs include safety, access to emergency treatment and continued health care, counselling, legal assistance, social support structures, validation and acknowledgement.[25] Victims also need to have their voices heard, to have information on the progress of their cases, and fair treatment while seeking recourse and redress.[26] In addition, victims have a right to access justice, to receive prompt support services as well as effective remedies and reparation. These victim needs and rights are recognised at national levels in both Kenya[27] and South Africa.[28] Constitutions in both countries safeguard the right to be free from all forms of violence, whether from public or private sources, alongside other fundamental human rights.[29]

There is increasing recognition that multi-sector approaches that integrate, at a basic level, health, legal, and psychosocial support services, are necessary in order to effectively address the multiple needs and rights of sexual violence victims'.[30] Integration centres, such as Kenyatta National Hospital's GBVRC, where Annette received support services, create platforms for such service integration, provided by multi-disciplinary teams of service providers.[31]

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[24] Kenya National Bureau of Statistics, *Demographic and Health Survey,* 2014.
[25] United Nations General Assembly, *Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power: resolution / adopted by the General Assembly*, 29 November 1985, A/RES/40/34.
[26] Ibid.
[27] Kenya Victim Protection Act 14 of 2014.
[28] South Africa Department of Justice and Constitutional affairs, *Victims Charter; a minimum Service Standard for Victims of Crime*, 2004.
[29] The Constitution of the Republic of Kenya, 2010, arts 26-29; The Constitution of Republic of South Africa, 1996, ss 7-12. Both these constitutions safeguard the right to equality and non-discrimination, life, human dignity, freedom and security of the person.
[30] Colombini, M., Dockerty, C. & Mayhew, S., 'Barriers and facilitators to integrating health service responses to intimate partner violence in low-and middle-income countries: A comparative health systems and service analysis' (2017) 48(2) *Studies in Family Planning* 179-200.
[31] Gruskin, S., Waller, E., Safreed-Harmon, K. et al., 'Integrating human rights in program evaluation: Lessons from law and health programs in Kenya' 2015 *New Directions for Evaluation* 57.

Multi-sector approaches have the potential to alleviate challenges experienced by sexual violence victims in the process of seeking recourse and accessing support services.[32] These persisting challenges are well documented and start from the reporting stage, through the investigation process, to trial in court.[33] Shame, stigma, self-blame, pressure from communities and family members, and the lack of faith in the police and the court systems continue to inhibit the reporting of this intimate violation.[34] Even where victims report, the lack of basic emergency treatment and care, demeaning attitudes by service providers, lack of access to medico-legal documentation, and forensic services discourage victims from seeking justice and weaken prospects of successful prosecution.[35] The process of investigation is also often encumbered by police misconduct, lethargy and negative stereotypes, which compromises access to justice.[36] If the case gets to trial, there are structural barriers that discourage victims from staying in the criminal justice system, such as the costs of attending court amidst tedious delays, poor communication of trial-related information and the failure to implement victim protection measures.[37]

Furthermore, common stereotypes are used to discredit sexual violence victims leading to attrition of cases from the criminal justice system.[38] These challenges have been linked to structures of gender inequality, which accept and normalise violence against women.[39] Studies have also documented challenges experienced by victims outside or alongside the

[32] García-Moreno, C., Zimmerman, C., Morris-Gehring, A., et al., 'Addressing violence against women: a call to action' (2015) 385.9978 *The Lancet* 1685.
[33] Machisa, M., Jina, R., Labuschagne, G. et al., *A Retrospective Study of the Investigation, Prosecution and Adjudication of Reported Rape Cases from 2012*, 2017.
[34] Watson, J. *The role of the State in addressing sexual violence: Assessing policing service delivery challenges faced by victims of sexual offences*, 2015.
[35] Bornman, S., Dey, K., Meltz, R. et al., *Protecting Survivors of Sexual Offences: The Legal Obligations of the State with regard to Sexual Offences in South Africa,* 2013; Nekura, R. *The Elusive Justice for Women; A critical Analysis of Rape Law and Practice in Kenya* (LLM thesis University of Cape Town 2015).
[36] Smythe, D. *Rape Unresolved* (2016).
[37] Machisa, M., Jina, R., Labuschagne, G. et al., above note 33; Nekura, R., above note 35.
[38] Artz, L. & Smythe, D., 'Case attrition in rape cases: A comparative analysis' (2007) 20.2 *South African Journal of Criminal Justice* 158 at 197; Daly, K. & Bouhours, B., 'Rape and attrition in the legal process: A comparative analysis of five countries' (2010) 39 *Crime and Justice* 565.
[39] Onditi, F. & Odera, J., 'Gender equality as a means to women empowerment? Consensus, challenges and prospects for post-2015 development agenda in Africa' (2017) 36.2 *African Geographical Review* 146-167.

conventional criminal justice system.[40] These include lack of emergency and continued support services, such as shelters, medical treatment, counselling, and rescue services.[41]

Multi-sector approaches are acclaimed as having the potential to facilitate holistic and harmonised interventions that ensure such challenges are not exacerbated by uncoordinated implementation efforts.[42] This is because fragmented interventions place additional, undue burdens on victims who have to be 'shuttled around the system'[43] when seeking assistance. This compromises quality and continuity of support services, further leading to secondary victimization.[44] As such, service integration is widely accepted as an effective implementation approach.[45] The one-stop centre integration model, which provides all relevant gender-based violence services under one roof, has particularly gained traction as a best practice model.[46]

1.3. Research Question

In this thesis, I ask the question, in what ways do service integration approaches in Kenya - there called GBVRCs - and South Africa – where they are called Thuthuzela Care Centres (TCCs) - contribute towards fulfilment of states' human rights obligations to address sexual violence against women? Using the framework of state responsibility to act with due diligence in addressing violence against women, the thesis aims to explore how these integration models contribute to fulfilment of the state obligations to prevent, protect, prosecute, punish and provide adequate redress to survivors of sexual violence.[47]

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[40] Kilonzo, N., Theobald, S.J., Nyamato, E. et al., 'Delivering post-rape care services: Kenya's experience in developing integrated services' (2009) 87 (7) *Bulletin of the World Health Organization* 555; Bornman, S., Dey, K., Meltz, R. et al., above note 35.

[41] Ibid.

[42] García-Moreno, C., Zimmerman, C., Morris-Gehring, A. et al., above note 32; United Nations Entity for Gender Equality and the Empowerment of Women at (UN Women) Virtual knowledge centre accessed at *http://www.endvawnow.org/en/articles/1564-one-stop-centres-osc.html?next=1565* on 30th July 2018.

[43] South Africa National Prosecuting Authority, *Thuthuzela Care Centre Blueprint*, accessed at https://www.npa.gov.za/sites/default/files/resources/public_awareness/TCC_brochure_august_2009.pdf on 30th July 2018.

[44] Artz, L. & Smythe, D., 'Losing ground? Making sense of attrition in rape cases' (2007) 22 *SA Crime Quarterly* 13.

[45] Keesbury, J. & Askew, I., *Comprehensive responses to gender-based violence in low-resource settings: Lessons learned from implementation,* 2010; Kilonzo, N. & Taegtmeyer, M., *Comprehensive Post-Rape Care Services in Resource-Poor Settings: Lessons learnt from Kenya*, 2005; UN Women virtual knowledge centre above note 42.

[46] Ibid.

[47] Abdul Aziz, Z. & Moussa, J., *Due-Diligence Framework; State Accountability Framework for Eliminating Violence against Women*, 2014.

1.4. Introducing the Case Studies: Integration Models in Kenya and South Africa

The focus of this study is to understand how integration models in resource constrained settings within Africa operate, using the case studies of Kenya's GBVRCs and South Africa's TCC integration models. South Africa's TCCs implement a one-stop centre integration approach, established by the National Prosecuting Authority in 1999 as part of a national anti-rape strategy.[48] The model aims to reduce secondary victimization, reduce cycle time to case finalization and improve conviction rates.[49] The TCCs engage a multi-disciplinary team of police, medical officers, prosecutors, social workers and crisis counsellors for better case management. To this end, the TCCs introduced the practice of prosecutor-guided investigations for rape cases with the centres being linked to specialised sexual offences courts to provide targeted criminal justice system response for sexual violations.[50]

Previous empirical studies generally conclude that the TCCs reflect a good and well-functioning integration model.[51] However, the model's greatest strength, the ability to integrate multi-sector responses, is also noted to be its greatest weakness, due to unequal sectoral involvement.[52] Existing studies find variations in TCC implementation, sometimes significantly, in terms of standards of service delivery, both across TCCs in the country and even within centres.[53] While TCCs continue to be scaled up nationally, with 55 centres currently established in the country,[54] scholars have advised the need to re-think what the TCC model defines as success, how this should be measured and the need to standardise implementation accordingly, before further scale up. [55]

Kenya's GBVRCs operate differently, since they are not as systematically established and thus not entirely a TCC comparator. Empirical studies on Kenya's GBVRCs are sporadic, given that the GBVRCs are practice-emergent, independent interventions, birthed from different

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[48] South Africa NPA TCC blue print, above note 43.
[49] Jordaan, S., Slaven, F., Louwrens, C., et al., *Thuthuzela Care Centres Compliance Audit and Gap analysis,* 2016.
[50] Artz, L., Smythe, D. & Leggett, T., *Reflections on integrated rape case management*, 2004.
[51] Jordaan, S., Slaven, F., Louwrens, C. et al., above note 49.
[52] Ibid.
[53] Ibid; Vetten, L., '*It sucks'/ 'It's a wonderful service': Post –rape care and the micropolitics of institutions*, 2015.
[54] Jordaan, S., Slaven, F., Louwrens, C. et al., above note 49.
[55] Vetten, L., above note 53; RTI International, *Final report on the compliance assessment of the Thuthuzela Care Centres with national Department of Health guidelines for managing HIV in the context of sexual assault care*, 2007.

partnerships comprising of different development partners, government departments and NGOs. The most comprehensive review of Kenya's GBVRCs was conducted by the Population Council, which showed that the integration approaches in Kenya function through a system of loose referral networks among the different service providers. [56]

Integration centres in Kenya have been lauded for aiming to improve the care and support of rape victims by enhancing case investigation, hence increasing the chances of successful prosecution.[57] These objectives are quite similar to those put forward in other jurisdictions, such as South Africa, as described above. Some Kenyan scholars refer to these as legal integration programs, since they incorporate legal aid services provided by non-governmental organisations to health services, through the GBVRCs.[58] Gruskin et al have evaluated three such programs and found that this integration resulted in improved health outcomes, more access to the legal system, consistent follow up of cases and victim empowerment.[59]

1.5. Gaps in Previous Empirical Studies

While studies have shown the effective use of integration models in high-income countries,[60] the current discourse questions, amidst limited evidence, whether integration approaches are applicable in low-resource settings within Africa.[61] Despite the dearth of high-quality studies evaluating integrated service delivery models in low-resource settings, these models are increasingly being established and scaled up in parts of Africa.[62] scholars have noted the

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[56] Keesbury, J., Onyango-Ouma, W., Undie, C. et al., *A Review and Evaluation of Multi-Sectoral Response Services ("One-Stop Centers") for Gender-Based Violence in Kenya and Zambia*, 2012.

[57] Kilonzo, N., Ndung'u, N., Nthamburi, N. et al., 'Sexual violence legislation in sub-Saharan Africa: the need for strengthened medico-legal linkages' (2009) 17.34 *Reproductive Health Matters* 10.

[58] Gruskin, S., Safreed-Harmon, K., Ezer, T. et al., 'Access to justice: evaluating law, health and human rights programmes in Kenya' (2013) 16 *Journal of the International AIDS Society* 18726.

[59] Ibid.

[60] Morrison, A., Ellsberg, M. & Bott, S., 'Addressing gender-based violence: a critical review of interventions' (2007) 22 *The World Bank Research Observer* 25. Other examples include the Sexual Assault Referral Centres (SARC) model implemented in England or the Sexual Assault Response Team (SART), equivalent of the SARCs in the USA. For a discussion of these models see Daly, K. & Bouhours, B., *Conventional and innovative justice responses to sexual violence,* 2011; Ledray, L. & Chaignot, M., *Evidence collection and care of the sexual assault survivor,* 2001; Nugent-Borakove, M.E., Fanflik, P.L., Troutman, D. et al., *Testing the Efficacy of SANE/SART Programs Do They Make a Difference in Sexual Assault Arrest & Prosecution Outcomes?,* 2006.

[61] Chomba E., Murray, L., Kautzman, M. et al., 'Integration of services for victims of child sexual abuse at the university teaching hospital one stop centre' 2010 *Journal Tropical Medicine* 1.

[62] Keesbury, J., Onyango-Ouma, W., Undie, C., above note 56; Bacchus, L. J., Colombini, M., Contreras Urbina, M. et al., 'Exploring opportunities for coordinated responses to intimate partner violence and child

need to strengthen the evidence base for how integration models in resource-constrained settings operate to ensure scale up efforts are relevant to the realities of different African contexts.[63]

Sexual violence service integration in low- and middle-income countries has been understood largely within the ambit of health system responses to violence against women.[64] This health system-focused understanding of integration has limited much of the discourse to intra-sector collaboration within the health sector. As a result, there is inadequate interrogation of multi-sector collaboration across sector lines, that is, legal, health and psychosocial service sectors.

Debates on integration have also focused on comprehensive post-rape care as part of critical and immediate health services.[65] As such the integration literature is confined to the emergency response phase of sexual violence, with limited consideration for long-term questions of how integration can facilitate prevention, protection and provision of adequate reparations for sexual violations. Miller notes that addressing violence against women primarily as a health issue makes it related to disease and to survival rather than a violation of human rights, which should be redressed.[66] The highly medicalised nature of sexual violence response focuses on the victim's suffering body as opposed to a human being whose rights have been violated, which tends to 'dis-empower "treated" persons, moving them from citizen to patient'.[67]

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maltreatment in low and middle income countries: a scoping review' (2017) 22 *Psychology, Health & Medicine* 135.

[63] Ibid; Colombini, M., Mayhew, S. & Watts C., 'Health-sector responses to intimate partner violence in low-and middle-income settings: a review of current models, challenges and opportunities' (2008) 86.8 *Bulletin of the World Health Organization* 635.

[64]Ibid; Kilonzo, N., Taegtmeyer, M., Molyneux, C., 'Engendering health sector responses to sexual violence and HIV in Kenya: Results of a qualitative study.' (208) 20.2 *AIDS care* 188; Chepuka, L., *Perceptions, experiences and health sector responses to intimate partner violence in Malawi: the centrality of context*, (Doctoral dissertation, University of Liverpool, 2013); García-Moreno, C., Hegarty, K., d'Oliveira, A.F.L. et al., 'The health-systems response to violence against women' (2015) 385 *The Lancet* 1567; Olle, L., *Mapping health sector and interagency protocols on sexual assault*, 2005.

[65] Kilonzo, N., Theobald, S.J., Nyamato, E. et al., above note 40; LVCT, *Post Rape Care*, *Integrating Multiple Gender Strategies to Improve HIV and AIDS Interventions: A Compendium of Programs in Africa*, 2009.

[66] Miller, A., 'Sexuality, Violence against Women, and Human Rights: Women Make Demands and Ladies Get Protection'2004 *Health and Human Rights* 16.

[67] Ibid at 40.

Other scholars have focused on service integration in terms of case management, specifically to strengthen medico-legal evidence for effective prosecution of sexual violence.[68] As a result of this focus, the formal criminal justice system has been idealized as the site of struggle and accepted as the most probable, if not the only, means of achieving redress for sexual violations. While criminal justice is important, it forms only part of the mechanisms through which sexual violence can be redressed.[69] The centrality of criminal justice in service integration takes away from broader considerations of the holistic fulfilment of a state's human rights obligations, beyond prosecution and criminal punishment.[70]

Another concern is that existing studies have generally construed effectiveness or successes of integration models based on unilateral analyses of sector-specific outcomes. Most studies have assessed integration models by focusing on narrowly conceptualised outcome indicators, such as immediate health or legal (criminal justice) outcomes, without linking these to victims' perspectives on long-term care and support. For instance, studies of South Africa's TCCs have either focused on the model's ability to improve health outcomes,[71] criminal justice system outcomes and case management[72] or the psychosocial support component.[73] Similarly, studies of Kenya's sexual violence integration approaches limit their analysis to aspects such as uptake of health services and adherence to treatment protocols[74] or post-rape health care, with a specific focus of facilitating medico-legal linkages.[75]

[68] Kilonzo, N., Ndung'u, N., Nthamburi, N. et al., above note 57; Artz, L., Smythe, D. & Leggett, T., above note 50.
[69] Smythe, D., Artz, L. & Combrinck, H., 'Caught between policy and practice: health and justice responses to gender-based violence.' 2008 *Crime, violence and injury prevention in South Africa: data to action*: 162; Artz, L., & Smythe, D., 'Feminism vs. the state? A decade of sexual offences law reform in South Africa' (2007) 21.74 *Agenda* 6.
[70] Manjoo, R., 'Introduction: reflections on the concept and implementation of transformative reparations.' (2017) 21 *Journal the International Journal of Human Rights* 1193.
[71] RTI International, above note 55.
[72] Artz, L., Smythe, D. & Leggett. T., above note 50.
[73] Vetten, L., above note 53.
[74] Ranney, M.L., Rennert-May, E., Spitzer, R. et al., 'A novel ED-based sexual assault centre in Western Kenya: Description of patients and analysis of treatment patterns' (2011) 28(11) *Emergency Medicine Journal* 927.
[75] LVCT, above note 65; LVCT, World Health Organization & Sexual Violence Research Initiative *Strengthening Gender Based Violence and HIV Response in Sub-Saharan Africa*, Report of Stakeholders Workshop held 30th – 31st July 2012; Kilonzo, N., Taegtmeyer, M., Molyneux, C. et al., above note 64; Kilonzo, N., Ndung'u, N., Nthamburi, N. et al., above note 57; Keesbury, J., Onyango-Ouma, W., Undie., C. et al., above note 56.

These approaches are useful in assessing performance on sector-specific outcome indicators of integration. However, they lack the holistic perspectives necessary to understand the complexities of inter-sector collaborations, and the role of integration in addressing multiple victims' needs and rights. Therefore, literature on sexual violence service integration does not adequately speak to how complexities of multi-sector collaborations frame service integration. Furthermore, it remains unclear, based on analyses of narrowly defined sector-specific targets, how the integration approaches address the multiple and complex needs and human rights of victims of sexual violence.

1.6. Purpose and Significance of the Study

The main purpose of this thesis is to understand how multi-sector collaborations, which integrate sexual violence services, are meeting the needs and fulfilling the rights of sexual violence victims'. This thesis locates the analysis of service integration within the purview of State responsibility in human rights by assessing how these integration models are contributing to the fulfilment of state obligations to address violence against women. In this way, this research responds to the need for empirical assessments to provide conceptual clarity on how the scope and content of a state's obligations to ensure human rights – in this study, specifically the right to freedom from sexual violence - are operationalized and measured in implementation.[76]

The thesis addresses the gaps in literature first by strengthening the evidence base for understanding the context of integration models in low-resource settings within Africa, including how implementation varies in different resource and geographical contexts, from rural, peri-urban to urban settings. In addition, by moving away from an analysis of immediate, separate, sector-specific outcome indicators, the research introduces a different perspective, which analyses service integration comprehensively, across multi-sectoral lines (health, legal, social welfare). I do this using a feminist human rights perspective, based on the framework of state responsibility to exercise due diligence in addressing violence against women. The due diligence concept, which expands the limits of state accountability to include

[76] Abdul Aziz, Z. & Moussa, J., above note 47.

human rights violations by non-state actors,[77] is a point of intersection where mainstream human rights meets a long-standing feminist agenda to politicise the personal.[78]

The merging of these discourses produces a feminist human rights perspective. This perspective is useful in foregrounding questions of state accountability for rights violations, while centring experiences of individual victims of violence, in the analysis of integration approaches.

This study also contributes to literatures on service integration and collaboration by arguing that understanding service orientation is key to defining parameters of a victim-centred integration approach. I draw from literatures on collaboration theory and nodal governance to unpack the complexities of multi-sector collaborations that frame the operations of service integration centres and their referral networks. I argue that service integration involves complex multi-sector collaborations, the governance of which has the potential to eclipse the needs and rights of sexual violence victims'.

The study shows that integration approaches in Kenya and South Africa exhibit different service orientations based on how stakeholders or sectors, as nodes within the networks, wield their knowledge, capacities, resources, mentalities, methods and institutional structures to prioritize certain network outcomes over others.[79] Using a feminist human rights lens reveals that there is a need to re-orientate integration models in a way that centres the needs and rights of victims rather than the competing institutional and sector mandates of network players.

The thesis findings also show that, although the integration centres operate as safe havens that seek to provide specialized services that are designated and separate from mainstream

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[77] Ertürk, Y., UN Special Rapporteur on violence against women its causes and consequences, *Integration of human rights of women and gender perspective; Due diligence standard as a Tool for the Elimination of Violence Against Women,* UN Doc. E/CN.4/2006/61, 2006.

[78] García-Del Moral, P., and Dersnah. M.A., 'A feminist challenge to the gendered politics of the public/private divide: on due diligence, domestic violence, and citizenship' (2014) 18.6-7 *Citizenship Studies* 661.

[79] Burris, S., Drahos, P. & Shearing, C., 'Nodal governance' 2005 *Australian International Journal of Legal Philosoph*y 30; Holley, C. & Shearing, C., 'A Nodal Perspective of Governance: Advances in Nodal Governance Thinking' in Drahos, P. ed., *Regulatory Theory: Foundations and Applications* (2017) 163.

processes, they are not removed from fundamentally flawed systems and structures in which they are embedded. I argue that in order to fulfil both the individual level and systemic level due diligence standard as a measure of state responsibilities,[80] service integration models need to operate in ways that go beyond creating safe havens or protected processes to shifting social and institutional norms, which are the root cause of violence against women.[81] Therefore, there is a need to re-think both service orientations and how deeply rooted institutional norms permeate the safe havens to compromise effective responses to victim needs and rights, especially through limited conceptions of justice, punishment and reparations for sexual violence.

1.7. Overview of Chapters

This first chapter has provided a background for my interest in the question of how sexual violence service integration approaches contribute to the fulfilment of state obligations to address sexual violence. Although multi-sector collaborations that integrate sexual violence support services are widely accepted as best practice, there is a need to strengthen the evidence on how integration models in resource-constrained settings operate. Existing empirical studies largely assess these integration models using narrowly construed, sector-specific outcome indicators, such as immediate health outcomes and criminal justice system outcomes.

This thesis aims to contribute to the literature by moving away from unilateral analysis of sector-specific components by using a feminist human rights lens to highlight questions of state accountability and clarify how human rights norms are operationalized in practice. I also draw from broader literatures on collaborations and nodal governance theory, which further contributes to the service integration literature by unpacking complexities of multi-sector collaborations and their governance. Unpacking these complexities lays the foundation for the feminist analysis, which demonstrates how competing sector mandates, in service integration approaches, have the potential to de-centre and eclipse the needs and rights of sexual violence victims'.

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[80] Manjoo, R., UN Special Rapporteur on violence against women its causes and consequences, *State responsibility for Violence against Women*, UN Doc A/HRC/23/49, 2013.
[81] Ibid, para 20.

In the next chapter, I review literature on sexual violence service integration and multi-sector collaborations. The chapter explores meanings and definitions of integration and multi-sector collaborations, discusses drivers, motivations and benefits of integration, as well as scepticisms of this ideal. I briefly historicize the proliferation of integration models in low- and middle-income countries, discussing main factors that affect the quality of integration models. Further, I discuss the barriers and facilitators of multi-sector collaborations, as well as the parameters for a victim-centred approach in integration. This chapter concludes with a summary of key literature gaps, showing how this study will contribute towards addressing them. This chapter also introduces two useful theories emerging from the literature, which I use to unpack complex relationships and operations of multi-sector collaborations that frame the operations of the integration centres. The first is collaboration theory, which is concerned with operations, difficulties and benefits of collaborative ventures. [82]The second is nodal governance theory which complements the former by focusing on the influences that the actors involved in a collaboration network have in shaping its design, nature and outcomes.[83]

In Chapter Three, I introduce the feminist human rights perspective by discussing state responsibilities to exercise due diligence in addressing violence against women. I narrow my focus here to explain why I see the human rights due diligence standard as a feminist human rights lens that is useful in the analysis of implementation efforts to combat sexual violence. The concept of due diligence is a point of intersection, where mainstream human rights discourse merges with the feminist theories that politicise sexual violence against women perpetrated by private individuals. These are the type of cases the TCCs and GBVRCs integration models support every day. This perspective is useful because it highlights questions of state accountability for the normalised sexual violations against women, while centring the needs and rights of individual victims' experiences in the analysis of implementation efforts to combat sexual violence.

I then discuss the research design and methods in Chapter Four. Here I explain my selection of the qualitative case-study approach, which provides in-depth understanding of service

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[82] Huxham, C., ed., *Creating Collaborative Advantage* (1996); Huxham, C. & Vangen, S., *Doing Things Collaboratively: Realizing The Advantage Or Succumbing To Inertia?* (2003).
[83] Burris, S., Drahos, P. & Shearing, C., above note 79; Holley, C. & Shearing, C., above note 79.

integration through the experiences of service providers and sexual violence victims'. I explain why I compare Kenya and South Africa, describe the process of selecting the eight integration centres that formed part of my research in the two countries, the research methods and interview participants. I discuss the conceptual framework, that is, a feminist human rights framework premised on the framework of state responsibility to exercise due diligence to prevent, protect, prosecute, punish and provide adequate redress for sexual violence.[84]

Chapter Five is a description of the research findings, which reveals that Kenya's GBVRCs and South Africa's TCCs operate different collaboration systems and integration approaches, focusing on some service outcomes as priority over others. Kenya's GBVRCs facilitate integration by primarily strengthening comprehensive health care and psychosocial support to improve health outcomes for victims, with weak linkages to legal and justice sector responses. On the other hand, South Africa's TCC model facilitates systematic linkages with criminal justice system actors to increase prosecution rates but have weak linkages to comprehensive health and psychosocial support services, including long-term victim support. In both country contexts, while multi-disciplinary teams of service providers collaborate to protect sexual violence victims, they are constrained by limited training, infrastructural and human resource gaps. There are also limited options for referral, especially for long-term victim support services. Both country case studies show that these challenges are exacerbated in rural areas where the centres are more resource constrained.

Chapter Six draws from collaboration and nodal governance theories to argue that these different integration approaches are service orientations that emerge, based on how each actor or sector exercises their capacities to influence the outcomes of service networks. Two main orientations emerge: South Africa's TCC model, which is orientated towards enhancing prosecution to improve legal outcomes, and Kenya's model which is invested towards comprehensive health care for victims. While these orientations contribute towards fulfilment of some state obligations, a feminist human rights lens reveals that they compromise the fulfilment of holistic state obligations by centring competing sector

[84] Manjoo, R., 'State Responsibility to act with Due Diligence in the Elimination of Violence against Women' (2013) 2.2. *International Human Rights Law Review* 240.

mandates, which eclipses and de-centres the needs and rights of sexual violence victims'. In addition, similar orientations emerge in both country contexts: response-focused orientation with unclear strategies on prevention and emergency, or crisis-focused with limited considerations for long-term support.

Although these orientations may be accepted as the nature of the integration models as conceptualised, the diminished attention to prevention and long-term support services compromises fulfilment of the state's obligations by jeopardizing the safety and well-being of victims who seek support at the centres. This chapter shows that service orientations that de-centre the needs and rights of victims of sexual violence have implications for individual level due diligence as derived from the state's responsibility. A system-centred mentality that focuses on primarily achieving the goals of service systems fails to flexibly address the multiple and complex needs of individual victims.

Beyond individual level due diligence, there is a need to consider systemic level due diligence as part of the state's responsibility as well. Therefore, in Chapter Seven, I show that although these integration centres seem to operate as safe havens, by providing targeted specialized responses to sexual violence, they are not removed from fundamentally flawed systems and structures embedding them. Therefore, unless states set as target the holistic transformation of systemic and structural gender inequality and discrimination, the flaws of deeply rooted institutional and social norms will continue to permeate the save havens.

Using the findings and analysis from these two case studies I propose what a victim-centred service integration approach might look like in Chapter Eight. I suggest five considerations that include; broadening conceptualizations of punishment and redress beyond criminal justice, re-considering the ambivalence of crisis centres, lifting the victim's burden, acknowledging the multiple and complex needs of victims, and enabling the victim's agency and capacity. A victim-centred approach to sexual violence service integration needs to move beyond system- centred mentality that prioritizes competing sector mandates and transcend specializations or the creation of safe havens to strategies that are conscious of broader systemic and structural flaws embedded into integration models.

CHAPTER 2

INTEGRATING SEXUAL VIOLENCE SERVICES THROUGH MULTI-SECTOR COLLABORATIONS: A REVIEW OF LITERATURE

2.1. Introduction

Multi-sector collaborations, partnerships, and strategic alliances are resounding ideals for policy implementation.[85] The increasing acknowledgement of complexities inherent in social problems has made collaborations across sectors, agencies, organizations, professions, and disciplines necessary.[86] Huxham and Vangen describe this global movement towards 'collaborative public service provision approaches in addressing social problems' as the 'joined up' rhetoric of the millennium.[87]

'Multi-sector collaboration' and 'service integration' have similarly become buzz words in violence against women interventions. It is widely accepted that women who experience violence have multiple and complex needs, which require multi-sector collaboration to ensure holistic intervention.[88] Human rights treaty bodies and monitoring mechanisms, such as the CEDAW committee,[89] and special procedures mandates at both global[90] and African regional level[91] continuously recommend that states adopt multi-sector approaches to address violence against women as part of their human rights treaty obligations. Other consensus-building global advocacy processes for women's rights, such as the Commission on the Status

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[85] Huxham, C., above note 82.

[86] Waddel, S. & Brown, L. D., *Fostering intersectoral partnering: A guide to promoting cooperation among government, business, and civil society actors* Vol. 13 (1997); Le Ber, M.J. & Branzei, O., '(Re) forming strategic cross-sector partnerships: Relational processes of social innovation' (2010) 49.1 *Business & Society* 140; Ouwens, M., Wollersheim, H., Hermens, R. et al., 'Integrated care programmes for chronically ill patients: a review of systematic reviews' (2005) 17.2 *International Journal for Quality In Health Care* 141; Curry, N. & Ham, C., *Clinical and service integration: The route to improve outcomes* (2010).

[87] Huxham, C. & Vangen, S., 'Leadership in the shaping and implementation of collaboration agendas: How things happen in a (not quite) joined up world' (2000) 43 *Academy of Management Journal* 1159.

[88] Krug, E., Dahlberg L.L., Mercy J.A. et al., 'The world report on violence and health' (2002) 360.9339 *The Lancet* 1083; Watts, C. & Mayhew, S., 'Reproductive health services and intimate partner violence: shaping a pragmatic response in Sub-Saharan Africa' (2004) 30.4 *International Family Planning Perspectives* 207.

[89] United Nations Committee on the Elimination of Discrimination Against Women (CEDAW), *CEDAW General Recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19*, 2017, para 40(e).

[90] Manjoo, R., above note 84.

[91] African Commission on Human and Peoples' Rights, *The Guidelines on Combating Sexual Violence and its Consequences in Africa*, May 2017, para 25.

of Women,[92] and the Beijing Platform for Action and its review processes[93]similarly encourage this ideal. Accordingly, states consistently highlight the establishment or scaling of integration models in response to sexual violence as a major success when reporting on implementation efforts under human rights monitoring procedures.[94]

Despite a dearth of high-quality studies evaluating integrated service delivery, these models are increasingly being established and scaled up in parts of Africa.[95] The 'one stop centre' integration model, which provides all relevant services under one roof, has particularly gained traction in low- and middle-income countries. Given the dearth of knowledge on how models in low-resource settings operate, the trend in literature is to complement the limited evidence emerging from developing economies with integration studies from developed countries.[96] Studies on integrated service delivery models in Africa comprise largely of descriptive, project evaluations and donor reports, describing input and output processes, indicators and outcomes. Reviews that attempt to scope the context of such models in Africa have often considered these reports as being of low quality and with limited theoretical underpinnings.[97]

Nonetheless, in this chapter I use these reports as components of the literature review since they form a significant portion of what is available for the continent. I trace the similarities in themes arising from these studies to reinforce their veracity, especially for studies in similar

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[92] UN Commission on the Status of Women, *Agreed Conclusions, Elimination and prevention of all forms of violence against women and girls*, Session 57, 2013, para 34.

[93] UN General Assembly, *Review of the implementation of the Beijing Platform for Action and the outcome document of the special session on Women: gender equality, development and peace for the twenty-first century* UN Doc E/CN.6/2005/2, at 6. In addition, one of the key elements of United Nations UNiTE global campaign to is to have all UN member States enshrine National multi-sectoral responses to address violence against women. See the UN Secretary-General's UNiTE to End Violence against Women campaign accessed at http://www.un.org/en/women/endviolence/ on 12th March 2018.

[94]Ertürk, Y., above note 77; UN General Assembly, *National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21, Kenya* UN Doc A/HRC/WG.6/21/KEN/1, 2015, para 38; UN general Assembly, *National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21, South Africa* UN Doc A/HRC/WG.6/27/ZAF/1, 2017, para 61, 64.

[95] Keesbury, J., Onyango-Ouma, W., Undie, C. et al., above note 56.

[96]There is a trend in literature where such reports are seen as being of low quality. See for example Morrison, A., Ellsberg, M. & Bott, S., above note 60 at 22; Bacchus, L.J., Colombini, M., Contreras Urbina, M. et al., above note 62.This trend is also discernible when one considers which studies form part of the systematic reviews on integration models in low and middle income countries, based on the inclusion/ exclusion criterion used. See for example Colombini, M., Mayhew, S. & Watts C., above note 63; Colombini, M., Dockerty, C. & Mayhew, S., above note 30.

[97] Morrison, A., Ellsberg, M. & Bott, S, above note 60.

contexts. To complement this grey literature, I include literatures on collaboration, cross-sector social partnerships, networks and service integration to understand issues of meaning, theories of collaboration, and complexities of service integration approaches.

Two useful theories emerge from the literature: collaboration theory[98] and nodal governance.[99] Collaboration theory is concerned with the operations, difficulties and benefits of collaborative ventures. Originally from organizational studies, it is rooted in the experiences of practitioners, and centres around two main concepts: collaborative advantage and collaborative inertia. Collaborative advantage is the desired outcome of any collaboration. This 'advantage' is gained when something is achieved that could not have been achieved by any one organization/sector acting alone.[100] The second concept, collaborative inertia, is argued to be the actual outcome of such multi-sector collaborations, which is often negligible despite significant efforts by stakeholders involved.[101]

This theory and literature on collaboration has been used to understand integrated gender-based violence services in contexts such as Zambia[102] the United States,[103] and Ireland.[104] A critique of this theory is that it may not adequately explain 'collaborative processes or governance structures in complex domains involving many and diverse actors.'[105] However, later developments of the theory have further articulated a three-part framework of governance in collaborations: structures, processes, and actors.[106]

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[98] Huxham, C., above note 82; Vangen, S. & Huxham, C., 'Nurturing collaborative relations: Building trust in interorganizational collaboration' (2003) 39 *The Journal of Applied Behavioural Science* 5.
[99] Burris, S., Drahos, P. & Shearing, C., above note 79; Burris, S., Kempa, M. & Shearing, C., 'Changes in governance: A cross-disciplinary review of current scholarship' (2008) 41 *Akron Law Review* 1.
[100] Huxham, C., above note 82.
[101] Huxham, C. & Vangen, S., above note 82.
[102] Cooper, K. R. & Shumate, M., 'Interorganizational Collaboration Explored Through the Bona Fide Network Perspective' (2012) 26.4 *Management Communication Quarterly* 623.
[103] Griffith, G., 'Lessons in collaboration from local domestic violence councils' (1997) 33 *Willamette Law Review* 931; Griffin, G., *An ideal model of inter-organizational collaboration: Evaluating the collaborative relationship of domestic violence service providers and child welfare agencies in Texas*. (Thesis for Master of Public Administration, Texas State University, 2011).
[104] COSC, *Domestic and Sexual Violence Services in Ireland: Service Provision and Co-ordination*, 2011.
[105] Selsky, J. W. & Parker, B., 'Cross- sector Partnerships to Address Social Issues: Challenges to Theory and Practice' (2005) 31 *Journal of Management* 6.
[106] Vangen, S., Hayes, J. & Cornforth, C., 'Governing Cross-sector, Inter Organizational Collaborations' (2015) 17 *Public Management Review* 1237.

Nodal governance theory further complements this approach by focusing on the influences that the actors involved in a collaboration network have in shaping its design, nature and outcomes.[107] Nodal theorists examine how actors within networks use institutional structures, resources, mentalities, and methods to influence the outcomes of the network.[108] In this way, nodal governance complements collaboration theory by articulating modalities of relationship between structures, processes and actors in a multi-sector collaboration.

This chapter is divided into five broad sections. I begin by looking at the meanings of integration and multi-sector collaborations, including different models or approaches of integration. I then discuss drivers, motivations and benefits of integration, as well as scepticisms of this ideal. In the third section, I look at the proliferation of integration models addressing sexual violence in low- and middle-income countries, and the factors affecting the quality of integration models. I go on to discuss complexities of multi-sector collaboration, including barriers and facilitators, as well as the parameters for a victim-centred approach in integration. I conclude by summarising key literature gaps and how this study will contribute towards addressing them.

2.2. Understanding Service Integration and Multi-Sector Collaborations

2.2.1. The Collaboration Continuum; Definitions and Meaning

Literature on multi-sector collaborations is broad, rich and diverse, with bodies of work spread across multiple disciplines, such as public health, organizational studies, public administration, business management, political science and sociology.[109] This diverse literature is the site of various conceptual frameworks, theoretical underpinnings, and definitions. While 'some of these literatures merge, [the] majority of them tend to speak past one another.'[110] Different, yet closely related words such as 'collaboration', 'partnership', 'co-ordination', 'alliances', 'network', and 'inter-organizational relations' are used

[107] Burris, S., Drahos, P. & Shearing, C., above, note 79.
[108] Ibid at 37; Holley, C. & Shearing, C., above note 79.
[109] Le Ber. J. M. and Branzei. O., above note 86; Durugbo, C. & Riedel, C. J., 'Readiness assessment of collaborative networked organisations for integrated product and service delivery' (2016) 54.12 *International Journal of Production Research* 3749.
[110] Silvia, C. & McGuire, M., 'Leading public-sector networks: An empirical examination of integrative leadership behaviours' (2010) 21.2 *The Leadership Quarterly* 264 at 264.

interchangeably to describe forms of collective action, leading to multiple interpretations, with no consensus as to their meanings.[111]

While some scholars have attempted to define some of these terms[112] others have settled that no fixed definitions are necessary, given the diversity of their usage in practice.[113] The latter argue that practitioners are often less concerned about abstract definitions than the actual doing of partnership or collaboration. Therefore, these scholars suggest that it is perhaps better having different definitions based on context and usage. [114]

In the absence of concrete definitions, within a context of varied interpretations, one way of understanding collective action has been to describe it as occurring on a continuum.[115] This continuum ranges from loose forms of collaboration among agencies in a network, often described as 'co-ordination' or 'co-operation', to more fused processes where agencies systematically organise functions into a comprehensive service package, often referred to as 'integration.' Darlington et al argue that the placement of a collective action within this continuum depends on levels of joint decision-making and degrees of resource sharing.[116] The more integrated modes of joint working are described as moving beyond general networking to partnerships. The difference is that, while networking may simply entail 'sharing work in relation to a particular client',[117] partnerships are seen to operate with more collective intentionality in terms of planning, decision-making and resourcing.

For instance, a report documenting Cape Town's Saartjie Baartman Centre as a best practice in integration describes the collaboration having taken 'a radical jump from networking to partnership work…because…the cross-cutting nature of domestic violence demands joint

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[111] Huxham, C., 'Theorizing collaboration practice' (2003) 5.3 *Public Management Review* 401.
[112] King, G. & Meyer, K., 'Service integration and coordination: A framework of approaches for the delivery of co-ordinated care to children with disabilities and their families' (2006) 32.4 *Child Care, Health and Development* 477.
[113] Gajda, R., Utilizing collaboration theory to evaluate strategic alliances. (2004) 25.1 *American journal of evaluation* 65.
[114] Huxham, C., above note 111.
[115] Austin, J. E., 'Strategic collaboration between non-profits and businesses' (2000) 29 *Non-Profit and Voluntary Sector Quarterly* 69.
[116] Darlington, Y., Feeney, J.A. & Rixon, K., 'Inter-agency collaboration between child protection and mental health services: Practices, attitudes and barriers' (2005) 29 *Child Abuse & Neglect* 1085 at 1086.
[117] Ibid.

efforts and the implementation of integrated approaches that cannot be provided by single organisations acting alone.' [118]

Literature on cross-sector social partnerships similarly shows this continuum approach to understanding collective action. For example, Cotton et al define these partnerships as a spectrum ranging from philanthropy and volunteerism on one end to integrated collaboration on the other.[119] In the latter, willing participants come to a mutual agreement on the purpose of collaboration and set long term goals.[120] Bryson et al similarly suggest that such partnerships generally involve a staged progression 'along a collaboration continuum; that is, from philanthropic to transactional to integrative relationships.'[121]

The term integration has its roots in organizational research.[122] In their seminal paper, Lawrence and Lorsch defined integration as 'the process of achieving unity of effort among the various subsystems in the accomplishment of the organization's task.'[123] While their interest was primarily focused on organizational management, this concept has since been applied and developed widely with reference to the provision of social welfare, health, legal, and other services through multi-sector collaboration.[124] Lawrence and Lorsch's definition similarly embodies a continuum element by framing integration not so much as a definable action, but as a process of enhancing the 'state of collaboration among departments that are required to achieve unity of effort'.[125] The quality of this state of collaboration depends on several factors which I discuss later in this chapter.

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[118] Saartjie Baartman Centre for Women & Children, *Input for the study on violence against women for the UN Division for the Advancement of Women,* 2005 at 2.
[119] Cotten, N. M. & Lasprogata. A. G., 'Corporate citizenship & creative collaboration: Best practice for cross sector partnerships' (2012) 18 *JL Bus. & Ethics* 9.
[120] Abramson, S. J. & Rosenthal, B.B., 'Interdisciplinary and interorganizational collaboration.' (1995) 2 *Encyclopaedia of social work* 1479.
[121] Bryson, M. J., Crosby, C. B., Stone, M. M., 'The design and implementation of Cross sector collaborations: Propositions from the literature' (2006) 66 *Public Administration Review* 44.
[122] Axelsson, R. & Axelsson, B. S., 'Integration and collaboration in public health—a conceptual framework.' (2006)21 *The International Journal of Health Planning and Management* 75.
[123] Lawrence, R. P. & Lorcsh, W. J., 'Differentiation and integration in complex organizations' (1967) 12 *Administrative science quarterly* 1 at 4.
[124] Axelsson, R. & Axelsson, B. S., above note 122.
[125] Ibid.

Axelsson and Axelsson develop Lawrence and Lorsch's work to find that many researchers use the word 'integration' due to contradictory meanings of 'collaboration' and other related terms such as 'co-ordination' and 'co-operation'.[126] To them, integration simply means 'bringing together different activities.'[127] These authors argue that this can be achieved vertically through hierarchical organisation, or horizontally through a network, where different actors volunteer to collaborate. Using institutional economic theory, they develop a conceptual frame, which also argues for the understanding of collective action in terms of a continuum.

This continuum is different from the one proposed by Lawrence and Lorsch because it is not linear, but multi-directional, resulting in four forms of integration that vary, based on the degree of hierarchical control (vertical integration) and voluntary collaboration (horizontal integration). These four forms are: contracting, co-ordination, co-operation and collaboration. This conceptual frame is useful in describing the degree of integration based on intensity of hierarchical control and extent of voluntary collaboration in a network or collective action. Their comparison of international integration approaches finds that most social service integration approaches happen through collaboration or co-operation between different agencies.

King and Meyer also build on the idea of a continuum of co-ordinated care to distinguish between 'service co-ordination' and 'service integration'.[128] To them service co-ordination is about ensuring a client can receive seamless and easy access to multiple services tailored to their care. In contrast, service integration deals with the macro level of service delivery, 'involving multiple actors forming a unified and comprehensive range of services to increase effectiveness'.[129]

Another way in which the literature derives meaning for collective action in providing public services is by using the terms 'co-ordination' or 'partnerships' with reference to agencies or

[126] Ibid.
[127] Ibid at 322.
[128] King, G. & Meyer, K., above note 112.
[129] Ibid at 479.

sectors engaging in a network. On the other hand, the term 'integration' is often used with reference to the different services being offered jointly by collaborating agencies. This approach is useful in terms of capturing the reality that, while collective action may result in a comprehensive integrated package of care, the agencies or sectors themselves hardly integrate. Collaborating partners in a network may share a common goal, but their individual mandates often remain separate and different.

Drawing from this literature, I use the word 'integration' in this thesis to mean the joining together or linking of legal, health and psychosocial support services, to address violence against women through multi-sector collaborations. I use the phrase 'integration approaches' with reference to the different patterns of multi-sectoral collaboration as operated in the national contexts, that is, Kenya or South Africa. I use the term 'integration models' to refer to the abstract ways in which different service interventions are joined or organised through activities of integration centres and network partners. This thesis compares two integration models; South Africa's Thuthuzela Care Centres (TCC) and Kenya's Gender Based Violence Recovery Centres (GBVRC), which act as platforms or main points of intersection for sexual violence services.

The terminologies I use in this dissertation differ somewhat from the language used in most of the literature on multi-sector interventions in the area of violence against women. A greater part of the literature uses the terms 'one stop centre' (OSC) or 'one stop crisis centres'(OSCC), whether with reference to centres already named as such, or when describing other multi-sectoral interventions that provide comprehensive care to victims of violence. I use the broader terms, 'integration models' or 'approaches', to allow for a wider understanding of approaches that may not fit neatly into descriptions of the OSC approach. I discuss the OSC as one form of service integration. This broader perspective challenges the underlying assumptions, within the violence against women service delivery literature, that all integration models are essentially different forms of OSC.

2.2.2. Integration as a Health System's Response to Violence against Women; Levels and Dimensions

With increasing recognition of violence against women as a global public health concern, the role of the health sector in both prevention and response has come under focus.[130] Public health literature on health systems responses to intimate partner violence and sexual violence dominates the integration discourse on violence against women. A large part of this literature focuses on understanding the effectiveness of the OSCC models, which aim to provide crisis services under one roof.[131] Here, integration is understood as combining two or more health services, which would otherwise be offered separately, into a comprehensive package of care.[132] This process could also involve adding new services to existing services. This approach is premised on saving costs and increasing technical effectiveness of service delivery, to maximise use of scarce resources.[133]

Service integration, as a health systems strategy, is not unique to violence against women services.[134] Other platforms of integration have been studied, such as integrating HIV services with sexual and reproductive health services,[135] or integrating Tuberculosis and HIV services.[136] The global push towards developing and improving health sector responses to violence against women comes as yet another opportunity for services to be 'integrated' or added on to existing health services. For instance, several studies recommend that sexual violence services should be integrated with HIV or antenatal services to offer a more comprehensive health response to sexual violence.[137] Proponents of the integration strategy

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[130] García-Moreno, C., Hegarty, K., d'Oliveira, A.F.L. et al., above note 64.
[131] Colombini, M., Mayhew, S. & Watts C., above note 63.
[132] Garcia-Moreno, C., 'Dilemmas and opportunities for an appropriate health-service response to violence against women' (2002) 359 *The Lancet* 1509.
[133] Dudley, L. & Garner, P., 'Strategies for integrating primary health services in low-and middle-income countries at the point of delivery' 2011 *The Cochrane Database of Systematic Reviews* 7.
[134] Zapata, T., Foster, N. & Campuzano, P. et al., 'How to integrate HIV and Sexual Reproductive Health Services in Namibia, the Epako Clinic Case Study' (2017) 17.4 *International Journal of Integrated Care* 1.
[135] Obure, D. C, Guinness, L., Sweeney, S. et al., 'Does integration of HIV and SRH services achieve economies of scale and scope in practice? A cost function analysis of the Integra Initiative' (2016) 92.2 *Sex Transm Infec* 130.
[136] Uyei, J., Coetzee, D. & Macinko, J., 'The influence of integrated tuberculosis and human immunodeficiency virus service delivery on patient outcomes' (2014) 18 *The International Journal of Tuberculosis and Lungaforgani Disease* 315.
[137] Hope, R., Kendall, T., Langer, A. et al., 'Health systems integration of sexual and reproductive health and HIV services in sub-Saharan Africa: a scoping study.' (2014) 67.4 *Journal of acquired immune deficiency syndromes* 259; Kilonzo, N., Taegtmeyer, M., Molyneux, C. et al., above note 64; Kilonzo, N., Ndung'u, N., Nthamburi, N. et al., above note 57; Liverpool VCT, above note 65.

argue that it has the potential to facilitate early detection of violence and hence lead to secondary and tertiary prevention through avoiding reoccurrence of violence.[138]

A key theme in this literature involves integrating these services into primary health care services, to facilitate access by communities at first point of service contact. Scholars find that such integration can be either structural or functional.[139] Structural integration is characterized by the provision of comprehensive services under one roof or within the same facility. [140] Functional integration goes further to entail coordination of health care activities beyond the structural aspect to ensure clients receive actual integrated services from health care providers.[141]

The main gap arising in this literature is that the analyses are limited to intra-sector integration, focusing on health services. There is no significant interrogation of inter-sector collaborations across sector lines, to cover health, legal and psychosocial services comprehensively. Issues of multi-sector collaboration are mentioned briefly through acknowledgement of the need to facilitate referrals to non-health services and the need to strengthen systems integration. However, there is limited consideration of the complexities of integrating services across sectors.[142]

In addition, the literature evaluating integration approaches uses narrowly conceptualised definitions of violence against women, in which certain forms of are presented as if mutually exclusive of each other. For instance, when assessing integration approaches, most studies focus either on intimate partner violence/domestic violence or sexual violence, without relating the two. Such divides may reflect practical and specific purposes for which service integration models were established to serve, for example addressing domestic violence or rape. However, women's experiences of violence do not often occur in ways that fit neatly

[138] Garcia-Moreno, C., above note 132.
[139] Kisubi, W, Farmer, F., Sturgis, R. et al., *An African response to the challenge of integrating STD/HIV- AIDS services into family planning programs*, 1997.
[140] Mayhew, S., Mutemwa, R., Colombini, M. et al., 'Putting the human into health systems: achieving functional integration of service delivery in Kenya and Swaziland. (2014) 14 *BMC Health Services Research 7*5.
[141] Ibid.
[142] Bacchus, L. J., Colombini, M., Contreras Urbina, M. et al., above note 62.

within such dichotomised categories. Women will often experience multiple forms of violence concurrently.[143] The separate analysis of domestic violence and sexual assault interventions presents a false dichotomy because it implies that domestic violence is hardly ever sexual, making forms of violence like marital rape invisible. Therefore, while the literature tends to be divided into studies on sexual assault and studies on domestic violence, I see this as a way of reinforcing the false dichotomy through research. For this thesis, I attempt to move away from this dichotomy by deliberately reading the literature on sexual violence service integration without this dichotomy in mind.

Some scholars have critiqued these narrow conceptualizations as inconsistent with the manifestations of sexual violence in African settings.[144] These scholars highlight the need to use broader and more nuanced ways of understanding integration models through acknowledging overlapping forms of violence and multiple pathways for victims.[145] From this perspective therefore, the focus on sexual violence in this study does not exclude intimate partner violence experiences. This dissertation contributes to the literature by expanding understanding of systems level integration through taking a broader perspective that analyses modalities of inter-sector collaborations. Using Kenya and South Africa as comparative case studies, I reflect on how integration of health, legal and psychosocial services contribute to improving state obligations to prevent and effectively respond to sexual violence against women.

2.3. Models of Integrating Sexual Violence Interventions

There are diverse forms of inter-agency relationships, ranging from loose coalitions established to pursue a single goal, to multifaceted networks integrating multiple services.[146] These networks may differ in character, for instance while some have short-term focus others are long term. Some may be formally structured or legally constituted, while others are more

[143] Kimuna, R. S., Tenkorang, Y. E., Dyamba, K. Y. et al., 'Gender based violence: Correlates of physical and sexual wife abuse in Kenya' (2008) 23 *Journal of Family Violence* 333.
[144] Henttonnen, M., Watts, C., Roberts, B. et al., 'Health services for survivors of gender-based violence in Northern Uganda: A Qualitative Study' (2008) 16 *Reproductive health matters* 122.
[145] Wangamati, K. C., Thorsen, C. V., Gele, A. A. et al., 'Post rape care services to minors in Kenya: are the services healing or hurting survivors?' (2016) 8 *International Journal of Women's Health* 249.
[146] Darlington, Y., Feeney, J.A. & Rixon, K., above note 116.

informally organised. In this section I highlight some integration approaches used to address sexual violence as identified or classified in the literature. Health systems literature identifies three levels of integration; provider level, facility level and systems level integration.[147] Since various conceptual frameworks and disciplines underpin the integration discourse, these categories are not mutually exclusive, and some do overlap.

2.3.1. Provider Integration

In provider integration, two or more services are provided by the same service provider.[148] For example, with regard to sexual violence services, a nurse would be capacitated to provide both treatment and trauma counselling services in one consultation. Building on Kisubi's work of functional and structural integration,[149] Obure describes provider integration as being more functional because it examines the extent to which clients receive multiple services from the same provider.[150] Colombini et al find that one main challenge of provider level integration is that the 'entrenched medical hierarchies may impede putting training on integrated service provision into practice.'[151]

2.3.2. Facility Integration

Facility level integration means that integrated services are provided by different providers but within the same facility or in one location.[152] Such models exist largely in high-income countries.[153] The OSCC approach in developing countries, such as the one pioneered in Malaysia, has been described as falling within this category because all or most services are co-located.[154] These centres are usually located in the accident and emergency departments in public hospitals, providing a range of integrated services such as health, legal and psychosocial. Major challenges of facility level integration are identified, including lack of sufficient infrastructure, physical space, equipment, and human resource gaps.[155]

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[147] Colombini, M., Mayhew, S. & Watts C., above 63.
[148] Ibid at 636.
[149] Kisubi, W., Farmer, F., Sturgis, R. et al., above note 139.
[150] Obure, C.D., Guinness, L., Sweeney, S., above note 135.
[151] Colombini, M., Mayhew, S. & Watts C., above note 63 at 636.
[152] Ibid.
[153] Ibid.
[154] Colombini, M., Ali, H. S., Watts, C. et al., 'One stop crisis centres: A policy analysis of the Malaysian response to intimate partner violence' (2011) 9 *Health Research Policy and Systems* 25.
[155] Colombini, M., Mayhew, S. & Watts C., above note 63.

King and Meyer's review of service delivery literature, which includes but is not limited to health services literature, identifies an integration approach that closely relates to facility integration. This is an agency-based integration approach that entails integrating services provided by different programs within one agency serving a specific catchment area.[156] In the context of sexual violence services this agency could range from a department within a hospital, to a stand-alone organization providing integrated support services to rape victims.

2.3.3. System/Sector Co-Ordination Approaches

Systems level integration is multi-site and involves external referrals to other sites for additional or specialised services.[157] In sexual violence interventions, the first two integration levels discussed above (provider and facility) centre on a combination of health services (sometimes including counselling) since most integration models are based in health facilities. One example of this systems integration approach is Bangladesh's Women's Friendly Hospital Initiative.[158] This integration project provides medical services on-site and has external referrals for legal and psychosocial services to other agencies or to hospitals in higher levels. Kenya's Nairobi Women's GVRC, has also been described as falling within this category, because the GVRC provides health services onsite and refers victims externally for legal services, economic empowerment, shelter and economic empowerment.[159] Although Colombini et al have described this GVRC mode of integration in broader multi-sectoral terms, systems integration within the health systems integration literature is primarily focused on intra-sector integration, and not often in relation to non-health services. The focus is on co-ordinated referral to other health facilities, for instance at a different facility level, often a higher-level facility within the health system for additional or specialised services.[160]

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[156] King, G. & Meyer, K., above note 112.
[157] Colombini, M., Mayhew, S. & Watts C., above note 63.
[158] Haque, Y. A. & Clarke, J.M., 'The Woman Friendly Hospital Initiative in Bangladesh setting: standards for the care of women subject to violence' (2002) 78 *International Journal of Gynecology & Obstetrics* 45.
[159] Colombini, M., Mayhew, S. & Watts C., above note 63.
[160] Ibid at 637; Goicolea, I., Vives-Cases, C., Sebastian, S. M. et al., 'How do primary health care teams learn to integrate intimate partner violence (IPV) management? A realist evaluation protocol' 2013 *Implementation Science* 36

King and Meyers' review of service delivery literature gives additional perspectives by arguing that system integration can indeed occur within sectors or across sectors.[161] To them system integration involves administrative planning on a systems-level, which involves 'gate keeping functions and fiduciary responsibilities, although client-specific service delivery activities may be involved.'[162] These authors describe the children's trusts in the UK as an example of systems-based service integration. They argue that systems-level integration involves joint visioning on objectives, joint planning and pooled budgets through formal agreements between sectors and a common assessment framework.

2.3.4. Family/Child/ Victim-based Integration

In addition to the system/sector-based and agency-based integration approaches, King and Meyers add a third approach, the client/family-based integration. Here, the focus is on assisting each specific victim or client to locate and access services they need in a geographical area.[163] This entails providing victims with advice, information, and skills to obtain services and other support they may require. Since this approach focuses on meeting the individual needs of different clients, there are no eligibility criteria, nor links to any specific service agency. Scholars posit that the operational models of this approach may vary depending on availability and capacity of service co-ordinators or case managers who provide the 'wraparound services'.[164]

VanDenBerg and Grealish use the case of emotional and behavioural disorders for children to describe this wraparound philosophy, which requires individualizing services and utilizing a community of resources organised on a collaborative system.[165] This approach challenges 'long traditions of pre-structured services which are based on limited categories due to narrow categorical funding strategies.'[166] VanDenBerg and Grealish caution that since this form of integration is flexible and not structured around any specific agencies,

[161] King, G. & Meyer, K., above note 112.
[162] Ibid at 482.
[163] Ibid.
[164] Ibid.
[165] VanDenBerg, E. J. & Grealish, M., 'Individualized services and supports through the wraparound process: Philosophy and procedures' (1996) 5 *Journal of Child and Family Studies* 7.
[166] Ibid at 9.

implementation may be difficult and slow and therefore it is rarely outcome oriented. Keesbury et al's review of integration models in Kenya and Zambia also uses this wraparound idea in their explanation of integration models found in Kenya and Zambia. [167] These scholars find that one of the three types of integration models found in these two countries is based in the health facility, owned by NGOs, and 'provides wraparound services that strengthen and expand existing clinical services provided by the health facility.'[168]

2.3.5. One Stop (Crisis) Centre Approaches

While some literature frames the OSC integration model as falling within the categories described above, others have described it as an integration approach by itself, with its own sub-set of varying categories or classifications. The characteristic feature of OSC is that requisite services are based in one physical location to avoid the trauma of a victim going to many places for services.[169] These services vary and may include medical treatment, counselling, secure accommodation, legal advice, and economic empowerment programs.

Some studies use broader definitions, which acknowledge a web of services in a referral system or network as a form of OSC, even though these services are not actually co-located. For instance, the review of integration approaches in Kenya and Zambia found three varying forms of OSC, based on where they are based and who owns them.[170] None of these three models provides health, legal, and psychosocial services under one roof, yet they are described as OSC. Examples of other integration models commonly described as OSC include South Africa's TCCs,[171] Rwanda's Isange Centre[172] and Malaysia's OSCCs.[173]

Vetten's study of the TCCs argues that although this model is described as a form of OSC, the TCC is one-stop only at the initial point of reporting and crisis and then becomes more multi-stop in terms of follow up and long-term care, if that happens.[174] The challenge of OSC

[167] Keesbury, J., Onyango-Ouma, W., Undie, C. et al., above note 56.
[168] Ibid at 4.
[169] Saartjie Baartman Centre for Women & Children, above note 118.
[170] Keesbury, J., Onyango-Ouma, W., Undie, C. et al., above note 56.
[171] Artz, L., Smythe, D. & Leggett, T., above note 50.
[172] Bernath, T. & Gahongayire, L., *Final Evaluation of Rwandan Government and One UN ISANGE One Stop Centre*, 2013.
[173] Colombini, M., Mayhew, S., Ali, S.H. et al., 'An integrated health sector response to violence against women in Malaysia: lessons for supporting scale up' (2012) 12 *BMC Public Health* 548.
[174] Vetten, L., above note 53.

identified in literature is that co-locating services is resource intensive and as such may not be transferable to low-resource settings.[175] Therefore, models in high-income countries in the global North[176] have been seen as more capable of co-locating services.[177]

An alternative argument is that such inter-agency models that integrate services increase both cost and technical efficiency of service delivery therefore maximizing scarce resources.[178] Cost effectiveness appears to be a key motivation for integration that is sited in many high-income jurisdictions such as Australia, the USA, and Europe.[179] Studies considering the cost effectiveness of such integration models in low resource settings in Africa and Asia however maintain that in the absence of established institutional structures and financing policies, this models remain expensive to establish and scale up.[180] Therefore, such partnerships may reduce costs in the short- term, but not when cost effectiveness does not factor externalities such as the cost of developing a collective strategy in contexts where basic infrastructural challenges are causing significant strain already.

To conclude, this section highlights different integration models with systems integration seeming most relevant for this study because it is inter-sectoral and involves referrals within collaboration networks. However, this literature also shows that due to the overlap among the different forms of integration, two or more levels or approaches of integration could exist concurrently.

2.4. Moving from Silo to Integrated Implementation Approaches: Motivations and Benefits of Integration

A key motivation for service integration arises from the recognition that women who experience sexual violence have multiple needs.[181] These needs include health care, legal

[175] Kenya Women and Children's Wellness Centre, *Baseline Survey Report on Knowledge, Attitude & Practices of SGBV State Duty Bearers in Kasarani District*, 2012.
[176] Daly, K., above note 60.
[177] UN Women virtual knowledge centre, above note 42.
[178] Obure, D. C, Guinness, L., Sweeney, S. et al., above note 135.
[179] Darlington, Y., Feeney, J.A. & Rixon, K., above note 116.
[180] Keesbury, J., Onyango-Ouma, W., Undie, C. et al., above note 56; Colombini, M., Mayhew, S., Ali, S.H. et al., above note 173.
[181] Smythe, D., Artz, L., Combrinck, H. et al., above note 69.

advice, police investigation services, counselling or psychological care, and access to a safe house or shelter services.[182] Lack of co-ordination among the different actors providing these services leads to fragmented interventions that compromise victim health and psychosocial outcomes,[183] cause secondary victimization, and lead to attrition of cases from the criminal justice system.[184] Integration reduces service fragmentation, ensures a smooth continuum of services, and increases efficiency by decreasing parallel services and therefore reducing overall costs.[185]

Proponents of integration see it as a tool that provides a solution to the challenges of victims being sent 'from pillar to post' when seeking support, which is not only tedious for the victim but may put her at risk of re-traumatization.[186] Secondary trauma may result when a victim is forced to recount her experience of violence multiple times at different points of service provision. [187] Secondary victimization can also arise from unnecessary delays due to weak referral systems and lack of support in manoeuvring complex processes of the different sectors involved. [188]

Multi-sector collaboration is necessary because no single agency or organisation can meet the multiple needs of the sexual violence victim alone. Huxham and Vangen's collaboration theory argues that the main purpose of inter-sector collaboration is to achieve collaborative advantage, insofar as that which is achieved could not have been achieved by any one organization or sector acting alone.[189] For Axelsson and Axelsson, integration of services becomes particularly important because the rise in specializations and professionalization of occupations has caused fragmentation of services, especially in social welfare systems.[190]

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[182] Shukumisa Campaign, *Report of monitoring the implementation of sexual offences legislation & policies,* 2012.
[183] Kilonzo, N., Taegtmeyer, M., Molyneux, C., above note 64.
[184] Artz, L. & Smythe, D., above note 44 at 14.
[185] King, G. & Meyer, K., above note 112 at 479.
[186] MacFarlane, C., Van Loggerenberg, C. & Kloeck. W., 'International EMS systems in South Africa: past, present, and future' (2005) 64.2 *Resuscitation* 145.
[187] Jordaan, S., Slaven, F., Louwrens, C. et al., above note 49.
[188] Ibid.
[189] Huxham, C. & Vangen, S., *Managing to collaborate: The theory and practice of collaborative advantage* (2013).
[190] Axelsson, SB. & Axelsson, R., 'From territoriality to altruism in inter-professional collaboration and leadership' (2009) 23.4 *Journal of Inter-Professional Care* 320.

Therefore, inter-professional collaboration is necessary and becoming increasingly common through the formation of multi-disciplinary teams, particularly in health and social welfare.

In low-resource settings within Africa, poverty, and lack of access to infrastructure and other resources often means that victims of rape will have compounding needs, and impeded access to the requisite support services.[191] Integration offers a way of possibly reducing the cost of obtaining services for the victim, especially when services are co-located or facilitated through one service provider.[192] Therefore, 'a key policy driver for collaboration is perceived as efficiency or seamlessness of services to the citizens.'[193] Gruskin et al's evaluation of legal integration programs in Kenya finds that incorporating legal aid into existing health services can improve health outcomes, and means of redressing human rights violations.[194]

There are multiple other motivations and incentives why agencies collaborate to deliver services. For instance, Selky's review of organizational research identifies three motivation platforms for collaboration: resource dependence, social issues and societal sector.[195] The resource dependence platform concerns public-private partnerships, joint-ventures and other alliances, mainly motivated by the need for competitive advantage simply to meet their own needs. This literature does not consider the need to jointly address social issues as constituting such a potential advantage. The social issues platform, which is more relevant for this study, arises from literature on social problem solving. Here Selsky argues that interest groups are seen as stakeholders of 'issues', not of organisations.

For Selsky, the motivation for integration here is that some social issues are metaproblems exceeding the scope of any single actor. In this situation sexual violence would be the 'issue',

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[191] Womersley, G., & Maw, A., 'Contextualising the experiences of South African women in the immediate aftermath of rape' 2009 *Psychology in society* 40; Kilonzo, N, Molyneux. S, Taegtmeyer. M, et al., *Post rape services in Kenya: a situation analysis*, 2003; Christofides, N., Jewkes, R., Naomi, W. et al., 'Other patients are really in need of medical attention: the quality of health services for rape survivors in South Africa' (2005) 83 *Bulletin of the World Health Organization* 495.

[192] The Saartjie Bartman Centre in Cape Town explains that their model of co-location of services works in South Africa's context where the women they support hardly have money for transport to move from one point to another. Saartjie Baartman Centre for Women & Children, above note 118.

[193] Vangen, S. & Huxham, C., 'Enacting leadership for collaborative advantage: Dilemmas of ideology and pragmatism in the activities of partnership managers' (2003) 14 *British Journal of Management* 61 at 62.

[194] Gruskin, S., Waller, E., Safreed-Harmon, K. et al., above note 31 at 16.

[195] Selsky, J. W. & Parker, B., above note 105.

too complex for a single sector alone to effectively respond to. The societal sectors platform acknowledges that traditional sector boundaries in society can be blurred. For example, roles of government and non-profits can become blurred when the government contracts out welfare service provision to non-profits. This may result from the failure of the state to fulfil its obligations to provide these services or as part of shifting governance dynamics in public service provision.

This blurring of roles is evident in sexual violence integration models where governments contract non-governmental women's rights organisations to provide social welfare, counselling or legal services to victims.[196] It then becomes important to foster strategic multi-sector collaboration to effectively harness the capacity of these NGOs and the requisite state resources for the benefit of victims. Nodal governance theorists posit that the reality of polycentric governance, especially in developing countries is that other relevant stakeholders could either 'reinvent government',[197] where for instance NGOs would take over the responsibilities of the state, or 'reinvent governance' where other actors would capacitate and strengthen the state to provide these services.[198]

2.5. Smokescreen and Bureaucracy? Scepticisms of Integrating Sexual Violence Interventions

Analysts of collaborative partnerships argue that multi-sector approaches can become platforms of bureaucracy, which, in the end, compromise the very objectives of joint response to multiple and complex victims' needs. For example, Harvie and Manzi use a longitudinal case study to reflect on years of monitoring integration of sexual violence interventions in the UK since the 1990s, [199] when integration first became 'flavour of the month'.[200] They show how the multi-agency approach was used as a platform to 'supplant feminist ideologies on how to effectively respond to domestic violence, with judicial processes and bureaucratic

[196] Vetten, L., *A review of the national Department of Social Development's budgets between 2009/10 and 2013/14*, 2014.
[197] Burris, S., Kempa, M. & Shearing, C., above note 99.
[198] Ibid.
[199] Harvie, P. & Manzi, T., 'Interpreting multi-agency partnerships, Ideology, discourse and domestic violence.' (2011) 20 *Social & Legal Studies* 79.
[200] Hague, G., 'Interagency work and domestic violence in the UK' In *Women's Studies International Forum* (1998) 21.4. 441-449.

politics.'[201] Three dominant discourses emerge, which are at play in this bureaucratic processes that distracts integrated sexual violence interventions from meeting the needs of women victims: the criminal justice, managerialism and equalities discourses.[202]

The criminal justice discourse is emphasised in sexual violence service integration through the focus on strengthening medico-legal linkages.[203] Sceptics of this medico-legal linkages approach argue that it is a narrow focus that limits the legal response to criminal justice only and limits the health response to forensic examination. For example, Harvie and Manzi argue that the introduction of collaborative partnerships to reduce crime in the UK pushed for a one-dimensional criminal justice discourse, which displaced feminist political discourse on power and control.[204] Similarly, Beckett's review of integration approaches in New Zealand shows that feminist writers were discontent with the limited medico-legal focus of integration and argued for an integrated approach that was socio-legal.[205] This is approach recognises that it is not enough to have specialised medico-legal services, but that specialised services should be delivered through collaborative systems factoring in long-term physical and psychosocial consequences of sexual violence.[206]

In addition to the criminal justice discourse, managerialism, is identified by scholars as another bureaucratic discourse that cripples multi-sector collaborations integrating sexual violence services, by focusing on short-term performance indicators. [207] Harvie and Manzi argue that, while short-term monitoring of sector performance is important, it is the long-term oriented responses that are more indicative of the needs and rights of women who

[201] Harvie, P. & Manzi, T., above note 199 at 79.
[202] Ibid.
[203] See for example: Liverpool VCT, above note 65; Kilonzo, N., Ndung'u, N., Nthamburi, N., et al., above note 57; Du Mont, J. & White, D., *The uses and impacts of medico-legal evidence in sexual assault cases: A global review*, 2007.
[204] Harvie, P. & Manzi, T., above note 199.
[205] Ibid. Lievore, D., *No longer silent: A study of women's help-seeking decisions and service responses to sexual assault*, 2005.
[206] Beckett, L. L., *Care in collaboration: Preventing secondary victimisation through a holistic approach to pre-court sexual violence interventions* (Doctor of Philosophy Thesis, Victoria University of Wellington, 2007).
[207] Harvie, P. & Manzi, T., above note 199.This study was a long-term study and as such it monitored the unfolding nature of multi-agency working through various stages of transition. The study finds that short-term target setting in integration is incapable of facilitating the requisite emotional engagement necessary to effectively address complex needs of victims of violence.

experience violence.[208] This concern was similarly highlighted in one study of South Africa's TCC, where prosecutors suggested that the push by senior management towards increasing numerical targets of finalised cases jeopardised the process of justice.[209] This appraisal approach taken by the prosecutorial management compromises the ability of prosecutors to spend time with victims to build stronger cases.

The third dangerous discourse, the equalities discourse, is argued as having the potential to ensure that integrated sexual violence services remain nothing more than a smokescreen. The critique here is that simplistic applications of equality, when applied through gender neutrality,[210] can begin to incorporate men's experiences of violence on an equal basis with women's, without considering the historical context of gendered inequalities. As a result of this neutrality, in the case of integrating sexual violence services, attention can be diverted from providing services in a way that acknowledges the gendered root causes and consequences of violence against women, to having an intervention aimed at catering for men and women's experiences similarly. For instance, Harvie and Manzi find that, in the case of sexual violence service integration in the UK, the shift in discourse from male power and control to gender neutrality led to a shift in practice, where Domestic Violence Units were converted into Community Safety Units dealing with a myriad of other general issues, such as hate crimes.[211]

Beyond the UK's context, other scholars have highlighted the challenge of having sexual violence interventions, which were providing specialised services for women, being opened up to men victims on an equal basis.[212] Concurrently, women's rights organisations loose relevance in these spaces and funding for women's shelters and psychosocial components

[208] Ibid.
[209] Artz, L., Smythe, D. & Leggett, T., above note 50.
[210] Neutrality here means that service provision models address violence in a way that is not conscious of the gendered historical and root causes of violence against women. Manjoo, R., UN Special Rapporteur on violence against women its causes and consequences, *Developments in the United Nations regarding violence against women over approximately 20 years,* UN Doc A/HRC/26/38/2014.
[211] Harvie, P. & Manzi, T., above note 199 at 90.
[212] Fisher, E., 'Perpetrators of domestic violence: co-ordinating responses to complex needs.' (2011) 8 *Irish Probation Journal* 124.

continues to diminish.[213] It is therefore important to reflect on why certain sexual integration models are established, and also to monitor and evaluate the trajectory that these models take over time. Hague argues that, while multi-sector collaborations may seem like 'a creative way forward on one hand, they may also disguise inaction on the other.'[214]

2.6. Proliferation of One Stop (Crisis) Centre Integrated Sexual Violence Interventions in Low- and Middle-Income Countries

The move towards integrated responses to sexual violence in low- and middle-income countries escalated in the 1990s, particularly through the OSCC model. The first OSCC was established in Kuala Lumpur Hospital, the largest public health facility in Malaysia, in 1994.[215] This crisis centre was part of a health systems response to provide 24-hour patient-centred services for women and children who were victims of physical, emotional and sexual violence. Services provided include medical, social welfare, and police investigation through an established referral network. Following the perceived success of the Kuala Lumpur Centre, the model was scaled up nationally through a directive from the Ministry of Health that every hospital should have one.[216] However, not all the centres replicated successfully in the scale up. Major challenges included the structural and organisational challenges of the health systems, lack of clear protocols on roles and responsibilities of different actors, human resource gaps, lack of vibrant NGOs in the other regions, and the lack of political will and support.

Following from Malaysia's OSCC, similar models were replicated in other South-East Asian countries such as Thailand,[217] Bangladesh,[218] Melanesia and Timor-Leste.[219] In some settings the health sector took the lead on most services. For instance, in Thailand, most services were

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[213] Harvie, P. & Manzi, T., above note 199; Robinson, A. L. *The Cardiff Women's Safety Unit: A multi-agency approach to domestic violence, Final Evaluation Report*, 2003.
[214] Hague, G., above note 200 at 441.
[215] Colombini, M., Ali, S., Watts, C. et al., above note 154 at 25.
[216] Colombini, M., Mayhew, S., Ali, S.H. et al., above note 173 at 548.
[217] Grisurapong, S., 'Establishing a one-stop crisis centre for women suffering violence in Khonkaen hospital, Thailand' (2002) 78 *International Journal of Gynecology & Obstetrics* 1.
[218] Bairagi, G., Chanda, B.K., Naher, N. et al., 'One stop crisis centre: A model of hospital-based service for domestic violence, burn & sexual assault survivors in Bangladesh' (2006) 25 *The ORION Medical Journal* 25.
[219] Ellsberg, M., Heilman, B., Namy, S. et al., *Violence against Women in Melanesia and Timor-Leste: Progress made since the 2008 Office of Development Effectiveness Report, International Center for research on Women and Australian Agency for International Development*, 2012.

provided by hospital staff, including legal assistance, with NGOs being called in only when necessary.[220] Common challenges documented across these integration models include staffing gaps, weak referral linkages to external services, lack of sufficient budget, and technical support from relevant ministries.[221] Studies identify follow up as a main challenge in service integration, with the main reason for this challenge being the lack of capacity or resources to trace the progress of each single case.[222] However, some contexts have attempted to overcome this through strategies such as strengthening modes of referral, as in the case in the Philippines, where 'each centre was required to follow up the case until the referral process was successful.'[223]

In Africa, several countries moved towards integration in the late 90s, with different integration models being established in countries such as Rwanda,[224] South Africa,[225] Kenya,[226] Zambia,[227] Tanzania,[228] and Uganda.[229] While these multi-sector response models developed under different circumstances and in different contexts, the underlying theme remains to foster multi-sector collaboration to improve the quality of violence against women interventions. Most of these integration models are facilitated through partnerships with government and NGOs, including international donors. Most centres are based in health facilities and led by Ministries of Health. However, in other contexts, integration models are spearheaded by different state agencies, such as prosecution authorities in the case of South Africa's TCCs, or the police in the case of Rwanda's Isange Centre.

[220] Grisurapong, S., above note 217.
[221] UNFPA, *Health Sector Response to Gender-based Violence: An Assessment of the Asia Pacific Region,* 2010; Human Rights Watch, *Everyone blames me: Barriers to justice and support services for victims of sexual assault survivors in India* (2017) accessed at https://www.hrw.org/report/2017/11/08/everyone-blames-me/barriers-justice-and-support-services-sexual-assault-survivors on 18th July 2018.
[222] Ibid.
[223] Jina, R., *The use of evidence for improving the delivery of post-rape care in South Africa* (Doctor of Philosophy thesis, University of Witwatersrand, 2016) at 51.
[224] Bernath, T., Gahongayire, L., above note 172.
[225] South Africa's TCC Blueprint, above note 43.
[226] Keesbury, J., Onyango-Ouma, W., Undie, C. et al., above note 56.
[227] Ibid; CARE International, *One-Stop Model of support for survivors of gender-based violence: Lessons from Care Zambia,* 2013.
[228] Simmons, K., Zuki, M. & Messner, L., *Lessons from the Gender- Based Violence Initiative in Tanzania,* 2016.
[229]Henttonnen, M., Watts, C., Roberts, B. et al., above note 144.

Most integration models in low- and middle-income countries are dependent on donor funding, both in terms of establishment of the centres, training, and facilitation of partnership-building activities.[230] While most centres will operate within the state's infrastructure, such as hospitals, or gender desks within existing police stations, some are established as stand-alone centres.[231] The stand-alone approach has been described as being wholly owned or facilitated by NGOs who implement vertical programs.[232] These programs are hierarchically organised collaborations, often funded for specific, highly specialised services, such as medical treatment, with limited integration to other interventions for violence against women.[233]

While studies from Western countries show effectiveness of OSC models in high-income countries there is concern about the 'acceptability and cost effectiveness of this approach as currently applied in the African context'.[234] Some studies argue that the OSC model is inherently resource intensive and therefore it is only effective in high-income countries due to the availability of institutional structures, resources and capacity to facilitate this integration model.[235] As such, critics have raised questions of sustainability, and feasibility of the OSC model in Africa, more so, given the fragility of conflict or post-conflict settings, which characterises many developing countries.[236] According to this critique, decisions on which integration model to implement need to be weighed against available resources and informed by local needs.[237]

2.7. Complexities of Multi-Sector Collaborations: Barriers and Facilitators of Integration

[230] Garcia-Moreno, C., above note 132.
[231] Keesbury, J., Onyango-Ouma, W., Undie, C. et al., above note 56.
[232] Ibid.
[233] For example, projects implemented by Médecins Sans Frontières (MSF) or Doctors without borders. See the MSF Lavender house operated in Mathare slums in Kenya accessed at http://www.msf.org/en/article/kenya-recovering-sexual-violence accessed 11th April 2018.
[234] Keesbury, J., Onyango-Ouma, W., Undie, C. et al., above note 56.
[235] Kelly, L., Promising practices addressing sexual violence. Metropolitan University, 2005; Ellsberg, M., Arango, J.D., Morton, M. et al., 'Prevention of violence against women and girls: what does the evidence say?' (2015) 385 *The Lancet* 1555; Lovett, J., Regan, L. & Kelly, L., *Sexual Assault Referral Centre: developing good practice and maximising potentials*, 2004; McCoy, E., Butler, N. & Quigg, Z., *Evaluation of the Liverpool Multi-Agency Risk Assessment Conference (MARAC)*, 2016.
[236] UN Women Virtual Knowledge Centre, above note 42.
[237] Ibid.

From the literature on collaboration we see that a fundamental reason for multi-sector collaboration is to attain collaborative advantage, which is discussed above. This section considers the second concept in collaboration theory, collaborative inertia, which refers to the actual outcome of such multi-sector collaborations that is often negligible despite the significant efforts by stakeholders. In this section I unpack some of the complexities that may explain why integration models remain at collaborative inertia despite the best efforts of the actors involved. I also discuss the main facilitators of integration, as highlighted in the literature.

2.7.1. Competing Sector Mandates and Ideologies

A significant barrier to integrating sexual violence interventions is competing sector mandates, because collaborating sectors operate with different ideologies, discourses and conceptual frameworks.[238] As a result, stakeholders may not share joint goals, commitment and strategies. For instance, Artz and Smythe discuss how different sectors within the TCCs display different central aims that do not always complement each other. They argue that while the 'medical side of the TCC aims primarily to provide comprehensive medical care to the rape victim, the criminal justice side views the key objective as effective criminal justice management of sexual offences cases'.[239] This led, for example, to challenges over the proper completion of medico-legal documentation. Artz and Smythe's study found that prosecutors felt that, while the medical examination protocol was completed comprehensively upon examining the rape patient, the J88 legal evidence form was more of an afterthought, not capturing as much detail.[240]

In her reflection of working with domestic violence councils in the United States, Griffith argues that multi-sector collaborations are complex, because they are 'a maze of government agencies and other actors, each with an independent strategy on how to respond to domestic violence as they perceive it.' [241] For instance, while the health sector may be interested in addressing both short- and long-term health consequences of rape, prosecuting authorities

[238] Darlington, Y., Feeney, J.A. & Rixon, K., above note 116.
[239] Artz, L., Smythe, D. & Leggett, T., above note 50.
[240] Ibid.
[241] Griffith, G., above note 103 at 931.

or police may be interested in increasing conviction rates. To facilitate effective integration, therefore, she argues that each partner in the network needs to agree to 'give up autonomy voluntarily through a process of collaborative problem solving towards a commonly defined goal.'[242] Stakeholders in an integration approach would then work from a point of joint commitment to a commonly shared goal and strategic plan. This means that partners will need to align their internal goals and ways of measuring them to reflect the joint strategy developed collectively.[243]

2.7.2. Determining and Measuring Key Outcomes of Integration

The lack of agreement on what 'success' is for a multi-sector intervention and how key outcomes will be evaluated can be a barrier to service integration.[244] In the first evaluation of the TCCs, conducted in 2003, Artz and Smythe state that their assessment of the model was limited to formally stipulated aims as stated by the National Prosecution Authority, the TCC lead agency.[245] Subsequent studies of the TCCs have highlighted the challenges of assessing success based on measures prescribed by one stakeholder without meaningful involvement of other stakeholders involved.[246] Herbert and Bromfield, writing in the context of Australia, argue that even the most developed integration models hardly ever have a coherent theory of change, where all sectors agree on how joint outcomes will be achieved and measured.[247] Their work shows that, often, such programs rely on a set of principles assuming that these will contribute holistically to joint outcomes. To facilitate a holistic evaluation of integration approaches it is important for all agencies to have a joint understanding on outcomes and how they will be achieved.

Suter et al attempt to address this question of how to measure success in service integration by reviewing integration models in multiple domains, highlighting ten principles on improving

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[242] Ibid at 957.
[243] Ibid; Shaw, S. & Allen, B. J., 'It basically is a fairly loose arrangement… and that works out fine, really." Analysing the Dynamics of an Inter-organisational Partnership' (2006) 9 *Sport Management Review* 203.
[244] Dowling, B., Powell, M. & Glendinning, C., 'Conceptualising successful partnerships' (2004) 12.4 *Health & Social Care in the Community* 309. Quotations used to show the idea of success is contested.
[245] Artz, L., Smythe, D. & Leggett, T., above note 50.
[246] Vetten, L., above note 53; Jordaan, S., Slaven, F., Louwrens, C. et al., above note 49.
[247] Herbert, J. & Bromfield, L., 'Better Together? A Review of Evidence for Multi-Disciplinary Teams Responding to Physical and Sexual Child Abuse' 2017 *Trauma, Violence, & Abuse* 1.

the quality of integration overcoming common barriers.[248] These principles include providing comprehensive services on a continuum of care; patient focus; good geographic coverage; standardised care across multi-disciplinary teams; using information technology; building organisational cultures and leadership; and paying attention to governance structures and financial management. These scholars developed a conceptual frame based on these factors.

2.7.3. Power Imbalances: The Tension between Efficiency and Inclusiveness

The power disparity among stakeholders that have different interests, coupled with unequal involvement of the sectors involved, is a barrier to integration.[249] Vetten argues that, due to different interests, 'South Africa's TCCs emerge as contested spaces where power struggles [are] played out between actors involved, with these battles locating agencies within hierarchical relationships to one another.'[250] According to Vetten, the TCCs' focus on prosecution and emergency medical services may have resulted in de-prioritisation of the mental health component of the integration model.

As in any project, power disparities can be addressed by tracing the history of the integration models, to establish which values or meanings have been prioritised over others and which issues actors have struggled for, in terms of purposes for which resources should be invested.[251] Nodal governance theorists argue that to understand complexities of networks, there is a need to analyse how individual actors exercise their powers to influence other actors, hence shaping network outcomes.[252] Different stakeholders, as 'nodes' within networks, can exercise their power based on how they use their knowledge, capacities, resources, ways of thinking, methods and institutional structures to shape the orientation of the network towards certain outcomes as priorities more than others.[253]

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[248] Suter, E., Oelke, N.D., Adair, C.E. et al., 'Ten key principles for successful health systems integration' (2009) 13 *Healthcare Quarterly Toronto Ontario* 16.
[249] Lewis, D., Bebbington, A., Batterbury, S. et al., 'Practice, power and meaning: frameworks for studying organizational culture in multi-agency rural development projects' (2003) 15 *Journal of International Development* 541.
[250] Vetten, L., above note 53 at 8.
[251] Lewis, D., Bebbington, A., Batterbury, S. et al., above note 249 at 554.
[252] Holley, C. & Shearing, C., above note 79.
[253] Ibid.

Broader collaboration literature highlights that one reason underpinning the failure to include all actors equally arises from attempts to balance between efficiency and inclusiveness.[254] From a pragmatic stance, fewer minds or actors can accomplish more tasks, within a short time, without the challenges of needing to build consensus among a large group of actors. On the other hand, excluding other actors' voices could mean that perspectives and avenues for other critical victim needs could be blocked in the attempt to be efficient. Ultimately every service integration model involving multiple sectors sits on either end of the spectrum. Below I discuss some of the facilitators of integration, as highlighted in literature, which may alleviate these barriers.

2.7.4. Co-Location, Communication and Team Meetings

Having all or most services in the same physical location is generally accepted as a key facilitator of integration because it eases communication between agencies. Where co-location is not possible, scholars recommend that strong, systemic linkages should be established across the sectors involved.[255] Other analysts have identified that consistent periodic meetings by interdisciplinary teams and actors at local, provincial and national levels facilitated integration.[256] These meeting platforms can foster a sense of community among the agencies involved, through re-energising service providers and increasing knowledge of each other's roles.[257] However, Doyle's review of multi-disciplinary team work shows that 'co-location communication and meetings are in themselves not sufficient for effective integration'.[258] Feng et al similarly argue that, since such multi-sector collaboration is a 'sophisticated social activity' and thus difficult, it therefore requires understanding and respect beyond having periodic meetings. [259]

2.7.5. Developing Altruism and Trust

[254] Vangen, S., Hayes, J. & Cornforth, C., above note 106.
[255] Colombini, M., Dockerty, C. & Mayhew, S. H., above note 30.
[256] Jordaan, S., Slaven, F., Louwrens, C., above note 49.
[257] Beckett, L., above note 206.
[258] Feng, J-Y., Fetzer, S., Chen, Y-W. et al., 'Multidisciplinary collaboration reporting child abuse: A grounded theory study' (2010) 47 *International Journal of Nursing Studies* 1483.
[259] Ibid.

Building professional altruism, which is 'an attitude of general concern for others', [260] and trust can be fundamental in resolving conflicts that result from territoriality in multi-disciplinary teams.[261] Axelsson and Axelsson's review of multi-sector rehabilitation programs in Sweden comprising diverse professionals such as doctors, social workers, lawyers, economists and psychologists, finds that trust across disciplines facilitated collaboration. [262] They found that trust was only built over time as the actors got to know each other. Initially, these different professionals operated in mutual suspicion due to 'prejudices resulting from territorial thinking.'[263] Altruism requires that various professionals and managers of different integrating agencies should be prepared to transcend their sectoral territories and sacrifice certain interests for a common purpose. This can facilitate integration by ensuring that victims' needs become centred rather than the different interest of the sectors or actors collaborating.

2.7.6. Strengthening Formal Partnerships, Informal Relations and Referrals

Scholars have found that having policy directives such as laws that legalise and formalise the establishment of integration models facilitate integration because it mobilises political will and requisite resources.[264] However in their analysis of integration models in low-income countries, Colombini et al find that the big 'P' of policies, that is, legal frameworks, was not as important as the small 'p,' meaning protocols and service delivery guidelines.[265] The latter were found to improve quality of care, treatment and legal documentation of cases. Similarly, Seddoh argues that, for collaborations between NGOs and governments, having memoranda of understanding or standard operating procedures that stipulate and delineate roles and responsibilities of each actor provide clarity and avoid duplication of roles.[266] This analysis

[260] Krebs, D. & Dale, T. M., 'Altruism and aggression' (1985) 2 *The handbook of social psychology* 1.
[261] Axelsson, S.B. & Axelsson, R., above note 190.
[262] Ibid.
[263] Ibid.
[264] Jordaan, S., Slaven, F., Louwrens, C. et al., above note 49; Grisurapong, S. above note 217.
[265] Colombini, M., Dockerty, C. & Mayhew, S., above note 30.
[266] Seddoh, J.E., 'Stakeholder perception on factors influencing NGO collaboration with government in family health education in the TEMA metropolis of the greater Accra region of Ghana' (2016) 4 *Global Journal of Political Science and Administration* 20.

shows that clarifying stakeholder roles addresses issues of uneven work-loads and tensions arising from overlapping work, which may improve overall functionality.

Another way to strengthen formal partnerships for effective integration is to gain high-level support from ministries involved, because integration becomes institutionalised in the state systems.[267] In addition, lack of capacity or willingness to participate for both the agencies involved and individuals working for the agencies is a significant challenge. Part of this may be due to resource challenges, or simply lack of willingness to participate on the part of individual service providers, which 'results in a less effective process of negotiation rather than collaboration.'[268] While strengthening formal partnerships has been noted as an important facilitator, informal relations are just as valuable for effective integration.[269]

2.7.7. Involving Community Structures and Participation

Literature shows that most collaborative interventions emphasize community involvement, although there is not sufficient consideration as to how to do this meaningfully.[270] The community in this regard means either the recipients of the services or other interest groups in a locality.[271] In Kenya, the Nairobi Women's Gender Violence Recovery Centre is noted to have linkages to community structures through training community leaders and activists on how to offer support and basic counselling for sexual violence victims.[272] Vetten argues that there is a need to link TCCs to community resources to expand services to long-term care, since the containment counselling services offered at the centres is only suited for emergency cases.[273]

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[267] Colombini, M., Mayhew, S., Ali, S. et al., above note 173.
[268] Giacomazzi, A. & Smithey, M., 'Community policing and family violence against women: lessons learned from a multiagency collaborative' (2001) 4 *Police Quarterly* 99.
[269] Selsky, J. W. & Parker, B., above note 105.
[270] Huxham, C. & Vangen, S., 'Ambiguity, complexity and dynamics in the membership of collaboration.' (2000) 53 *Human relations* 771.
[271] Ibid.
[272] Bacchus, L. J., Colombini, M., Contreras Urbina, M. et al., above note 62.
[273] Vetten, L., above note 53.

An integration approach that involves community resources, including informal actors such as clergy, moves beyond biases of agency-only teams.[274] This broad-based community approach is argued to facilitate integration because the community will take ownership of the process of solving violence as a social ill.[275] In the case of sexual violence, significant caution in this regard is necessary due to widespread negative social attitudes that stigmatise women victims. I discuss this below under the section on parameters for a victim-centred integration approach.

2.8. Governing Integration Models

While service integration literature is rich and diverse, Silvia and McGuire argue that the least considered 800lb gorilla in the room is how leadership and governance is enacted in multi-sector collaborations.[276] A greater part of the challenges and complexities highlighted in this chapter have implications for governance and leadership of integration models. These include issues such as the centralised management of TCCs; questions around who owns or leads the integration models; navigating competing sector ideologies in goal setting; resource allocation; strategy development and planning; dynamics of decision-making within cross-sector partnerships involving diverse actors such as local governments, donors, NGOs , among other issues. Therefore, governance within collaborations is an important theme.

The question of who is accountable or responsible in a multi-sector collaboration is not always obvious. In Artz and Smythe's evaluation of the TCC, the authors sought to understand the accountability chain of the TCC by asking respondents who owns the model.[277] While the lead agency, the National Prosecuting Authority was sometimes identified as the owner of the integration model, respondents consistently pointed out that as a partnership, everyone was involved. While the study found that equal engagement of all partners is crucial for sustainability of an integration project, there was disparity in perceptions of which actors

[274] VanDenBerg, E. J. & Grealish, M., above note 165.
[275] Ibid.
[276] Silvia, C. & McGuire, M., above note 110 at 264.
[277] Artz, L., Smythe, D. & Leggett, T., above note 50.

were responsible, and who was ultimately accountable for the success of the integration project.

Selsky argues that to understand multi-sector collaborations, there is a need to consider institutional dynamics within the collaborations, including power relations and the politics of how goals are set.[278] Building on the collaboration literature, Vangen and Cornforth have taken on Selsky's concern by using theories from management and governance in public sector collaborations. These authors suggest a three-part framework through which to understand the complexities of governance in collaborations: structures, processes and actors. [279] 'Structure' pertains to the different actors involved and structural connections between them, 'process' involves ways of communicating, decision-making and sharing responsibilities, and 'actors' are individuals with enough power and know-how to influence the collaboration agenda.[280] Using this frame, Vangen and Cornforth researched activities of a collaboration on neighbourhood regeneration in which the local city council assumed the position of lead agency, as the main convenor. They found that the city council had greater legitimacy to direct goals, allocate resources and be accountable for the network's activities.

A critique of this collaboration literature is that it does not adequately explain collaborative processes or governance structures in complex domains involving many and diverse actors.[281] Nodal governance theory complements the literature on collaboration and addresses this gap by providing a framework for understanding processes and relationships between actors involved in a collaboration network. Nodal theorists essentially examine how different actors in multi-sector collaborations use institutional structures, resources, mentalities and methods to influence or shape the outcomes of a collaboration network.[282]

Nodal governance is a theory which develops from scholarship that uses the idea of 'nodes' within networks to understand how governance is enacted in contexts where multiple sectors

[278] Selsky, J. W. & Parker, B., above note 105.
[279] Vangen, S., Hayes, J. & Cornforth, C., above note 106.
[280] Ibid.
[281] Selsky, J. W. & Parker, B., above note 105.
[282] Burris, S., Drahos, P. & Shearing, C., above note 79.

or actors are involved in governing.[283] A node is essentially a point in a network, and is defined as a site of governance within a network where knowledge, capacity and resources are mobilised to manage the course of events.[284] Nodal governance adopts a polycentric view of governance, which considers governance as effective only through the mobilization of knowledge and capacities of multiple actors or nodes that operate within or along networks.[285] Such networks, which are described as 'outcome-generating systems'[286] are in themselves quite complex, requiring the actors involved to develop forms of governance to adapt to the complexities of such systems. [287] The theory of nodal governance develops as one such adaptation, emerging mostly from literature on security governance.

In this literature, Shearing and colleagues challenge the traditional, hierarchical state-centred analysis of governance and argue that in today's world, multiple stakeholders are involved in the governance of security, besides state agencies such as the police, courts and prisons.[288] Other agencies and sectors such as non-governmental organisations, private corporations and community-based organisations are also critical stakeholders in security governance. These nodal theorists argue that a 'nodal' rather than a state-centred conception of governance is necessary because the later gives conceptual priority to only a limited set of actors involved.[289] The problem with focusing on the state is not only that it ignores the role of other other actors, but that it fails to capture the complex relationships and interactions among all the different actors involved in governance. Shearing and Wood argue that if the state is understood as simply one set of nodes, among many, then there is room to understand how other agencies and sectors interact with the state in governing security.[290]

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[283] Ibid. Shearing, C., 'A nodal conception of governance: Thoughts on a policing commission' (2001) 11 *Policing and Society: An International Journal* 259.
[284] Burris, S., Drahos, P. & Shearing, C., above note 79 at 37.
[285] Shearing, C. & Wood, J., above note 307.
[286] Burris, S., Drahos, P. & Shearing, C., above note 79 at 37.
[287] Holley, C. & Shearing, C., above note 79.
[288] Shearing, C. & Wood, J., 'Nodal Governance, Democracy, and the New ` Denizens' (2003) 30 *Journal of Law and Society* 400.
[289] Ibid.
[290] Ibid.

Nodal theorists describe four main characteristics of nodes; mentalities, resources, methods and institutional structures.[291] Mentalities are the ways of thinking about the matters that the node has emerged to govern. Nodes also have a set of methods or technologies that they use to exert influence over the course of events. In addition, nodes have resources to support their operations and affect the flow of events. Finally, nodes have a structure or institutional framework that is used to mobilize their resources, technologies and mentalities over time.[292] Therefore, beyond being points on networks, nodes have complex characteristics and they operate is a variety of ways as captured here by Holley and Shearing:

> Nodes govern under a variety of circumstances, operate in a variety of ways, are subject to a variety of objectives and concerns, and engage in a variety of different actions to shape the flow of events. Nodes relate to one another, and attempt to mobilise and resist one another, in a variety of ways to shape matters in ways that promote their objectives and concerns. [293]

Consequently, nodes can take various forms. They can be state departments, NGOs or even private firms operating in a network. The multi-sector service integration models that I assess in this thesis are networks that bring together different actors, across sectors to provide support services for victims of sexual violence. I see the individual agencies involved, such as state departments or NGOs, as nodes within a service provision referral network. These actors have different mandates, capacities, mentalities which can create tensions that affect how services are integrated. Shearing describes how large institutions with different departments can also be seen as an assemblage of several nodes.[294] Drahos equally writes about how some institutions especially in the civil society sector can integrate their actors to form 'a super structural node' so as to 'concentrate their resources to achieve a common goal'.[295] Therefore while different organisations can each be considered a 'node' within a collaboration network, a multi-sector agency that integrates different organisations can also be considered a 'node' in the context of a wider network.

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[291] Burris, S., Drahos, P. & Shearing, C., above 79.
[292] Ibid.
[293] Holley, C. & Shearing, C., above note 79 at 185.
[294] Shearing, C. & Wood, J., above note 288.
[295] Burris, S., Kempa, M. & Shearing, C., above note 99 at 27.

Thus, nodal governance is a fluid theory that embraces multi-site governance as a question to be determined empirically, in different contexts. The key strength of a nodal governance analysis is that it can be used to discuss how different actors interact with each other, regulate each other and access each other within their collaboration networks. The metaphor of 'networks' is useful because it conveys the idea that 'diffuse systems of governance involve multiple nodes or actors that interact in a wide variety of ways.'[296] Within these networks, nodes as structures govern through exercising their knowledge and capacities to manage the course of events.[297]

I glean from nodal governance because it is a theory with diverse application, used by scholars with different experiences but with a similar interest in understanding new forms of social organization and the governance of complex social networks.[298] For instance, Drahos uses nodal governance in the context of international trade to understand how networks of multi-national business corporations create circles of influence to establish a trade-based-approach to intellectual property. [299] Drahos's analysis shows how such an approach has affected access to essential medicines for developing countries due to strict patenting protections. In a different case study, Shearing and Burris use nodal governance in to analyse the Zwelethemba Model, a micro-governance platform that seeks to promote security and justice among poor South African communities.[300] These scholars show how local Peace Committees as 'nodes' collaborate with state agencies, local businesses, NGOs and other actors to change the way security and community development is being accomplished.

In addition, nodal governance has been applied in the context of restorative justice, where these same Peace Committees in South Africa have been described as forms of 'responsive

[296] Ibid at 13.
[297] Holley, C. & Shearing, C., above note 79.
[298] Burris, S., Drahos, P. & Shearing, C., above note 79.
[299] Ibid. Drahos, P., 'Intellectual property and pharmaceutical markets: a nodal governance approach.' (2004) 77 *Temple Law Review* 401; Braithwaite, J. & Drahos, P., *Global business regulation* 2000.
[300] Shearing, C. & Froestad, J., 'Nodal Governance and the Zwelethemba Model' in Quirk, H., Seddon, T. & Smith, G. eds., *Regulation and Criminal Justice: Innovations in Policy and Research* (2010) 103.

nodal governance'.[301] Other application contexts for nodal governance include the analysis of democratic governance in global health systems, [302] the regulation of the gambling industry in Australia,[303] and the governance of UN-Water, an inter-agency platform to coordinate the achievement of water related targets under the Millennium Development Goals.[304] Therefore, as an elaboration of contemporary network theory, nodal governance has been used in diverse case studies to explain 'how a variety of actors operating within social systems interact along networks to govern the systems they inhabit.'[305] This theory is unique to other social network theories, from which it emerges, because it focuses on analysing the dynamics of individual institutional actors or nodes within a network.[306]

In this thesis, I specifically use nodal governance to complement the literatures on collaboration theory because it hones in on analysing the dynamics of each institutional actor as a node within multi-sector collaboration service networks. I use this theory to analyse how individual actors or sectors use their resources, institutional structures, methods and mentalities to govern operations of the GBVRC and TCC multi-sector collaborations.[307] In chapter 6 especially, I use this thinking on nodes to discuss how different actors in the TCCs and GBVRCs work in a variety of ways to intentionally shape the flow of events, to orient the integration approaches in a way that promotes their objectives and concerns. Understanding service orientations is important because it allows for an assessment of whether the integration models are inclined to respond to the needs and rights of sexual violence victims. In other words, understanding service orientation allows for an analysis of how victim-centred these integration approaches are.

Hence, while Vangen's work on collaboration theory sets up structures, processes and actors as different aspects to consider in governance of multi-sector collaborations, nodal theorists

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[301] Wood, J., Shearing, C. & Froestad, J., 'Restorative justice and nodal governance' (2011) 35.1, International *Journal of Comparative and Applied Criminal Justice* 1 at 9.
[302] Burris, S. Governance, Microgoverance and Health. (2004) 77, *Temple Law Review* 335.
[303] Wright, J. S., & Head, B., 'Reconsidering regulation and governance theory: A learning approach' (2009) *31*(2) *Law & Policy* 192.
[304] Baumgartner, T., & Pahl-Wostl, C., 'UN–Water and its role in global water governance' (2013) 18(3) *Ecology and Society* 3.
[305] Burris, S., Drahos, P. & Shearing, C., above, note 79 at 33.
[306] Shearing, C. & Froestad, J., above note 300.
[307] Shearing, C. & Wood, J., above note 288.

move a step further to articulate the relationships between all these aspects. This study benefits from a reflection of both these theories and literatures in understanding operations of sexual violence integration approaches in Kenya and South Africa.

Broader questions of governance and defining good governance are outside the scope of this study. For purposes on this analysis I understand governance both in terms of the *process* of delivering good results and, perhaps more importantly here, as intrinsically linked to *normative* questions of what the governor is seeking to accomplish.[308] The normative framework that I use in this thesis is a feminist human rights framework that provides for state obligations to address violence against women, discussed in the next chapter. Therefore, for this study, good governance is that which is organised and oriented towards effective fulfilment of these rights-based state obligations to prevent and effectively respond to violence against women in human rights law.[309]

2.9. Parameters for Person/Client/Victim-centred Approach to Integration

One imperative for integrating sexual violence interventions is to move away from a 'system-centred' approach to a 'victim-centred' approach. The former is more concerned with accomplishing sector specific tasks, such as legal tasks assigned to police officers in terms of evidence gathering, rather than respecting multiple, complex needs of victims and inquiring after her wishes.[310] Victim-centeredness means that integrated services should be individualised to meet the needs of victims seeking support, 'rather than reflecting the priorities of the service systems.'[311] For example, having specialised prosecutors with a reduced work load and time to liaise with victims and their families to inform them of their case progression and reasons behind decisions has been noted as being part of a victim-centred approach.[312] Contrary to this example, a system-centred prosecutorial process would

[308] Burris, S., Kempa, M. & Shearing, C., above note 99.
[309] For a discussion of comparable human rights-based conceptions of governance see Asbjorn, E., 'Good governance, human rights and the rights of minorities and indigenous people' in Sano, H.O. & Godmundur, A. eds., *Human Rights and Good governance, Building Bridges* (2002).
[310] Beckett, L. L., above note 206.
[311] VanDenBerg, E. J. & Grealish, M., above note 165.
[312] Artz, L., Smythe, D. & Leggett, T., above note 50.

be one that is solely focused on increasing prosecution rates without regard to the needs of victims.

Vetten argues that to achieve victim-centeredness, an integration model needs to have flexible non-categorised funding. She argues that the nature of sexual violence service integration, that is, being comprehensive in design, scope and extent, should determine funding allocation and not the other way around.[313] In other words, the nature of comprehensive integration models should guide funding allocations rather than having predetermined funding categories shaping the nature of integration models.

For services to be victim-centred they should be culturally and linguistically competent and relevant, 'built on the values, social and racial make-up of the clients and families seeking services'.[314] This includes ensuring that integration models utilise community support structures and community resources as discussed above.[315] For example, Khamala and others emphasize the need to find psychosocial support approaches that work for the African context.[316] Kim and Motsei invite service providers to recognize the limits of professionalism through, for example, acknowledging cultural contexts of service providers who are first community members before they are health workers.[317] Being conscious of the cultural contexts will ensure that an integration approach is cognizant of the support systems available, as well as dangerous avenues where harmful social attitudes can be used to frustrate victims seeking support.

Victim-centred services should be unconditional.[318] This means that access to any one of the multiple services a victim may need should not be predicated on her having to take up any other related service. For example, one critique of Rwanda's Isange OSC model is that since the centre is based in a police hospital, victims of rape have to report the case to the police

[313] Vetten, L., above note 53.
[314] VanDenBerg, E. J. & Grealish, M., above note 165 at 9.
[315] Njuki, R., Okal, J. & Warren, C. et al., 'Exploring the effectiveness of the output-based aid voucher program to increase uptake of gender-based violence recovery services in Kenya: a qualitative evaluation.' (2012) 12 *BMC Public Health* 426.
[316] Wangamati, K. C., Thorsen, C. V., Gele, A. A. et al., above note 145.
[317] Kim, J. & Motsei, M., '"Women enjoy punishment": attitudes and experiences of gender-based violence among PHC nurses in rural South Africa' (2002) 54 *Social Science & Medicine* 1243.
[318] VanDenBerg, E. J. & Grealish, M., above note 165.

before they can receive health and other support services.[319] VanDenBerg and Grealish argue that for integrated services to be unconditional, service systems should be flexible enough to accommodate the changing needs of clients.[320] As such, should the victim's needs change, the system should not reject them, but rather the services should change in order to reflect the needs of victims. The adaptability of services allows for victims to exercise autonomy in deciding the course of action.[321]

With regards to criminal justice, the growing recognition of victim's rights has challenged the peripheral role that victims of crime occupy in criminal justice.[322] The issue of victim's rights is important because both Kenya's and South Africa's Constitution enshrines the right to be free from all forms of violence, whether perpetrated in public or private spheres.[323]

A victim-centred approach does not place undue burden on the sexual violence victim who is seeking recourse. As discussed above, integration as a strategy is expected to reduce the burdens that service systems can place on victims. However, without strong referral channels and communication mechanisms victims can still grapple with burdens such as the pressure to 'be available, follow up the case actively, assist in investigation and provide consistent, reliable information'.[324] In the context of policing sexual violence in South Africa, Smythe argues that while such expectations may seem realistic, they become problematic if they form the basis of determining whether a victim is worthy of protection. She posits that heightening these expectations coupled with police non-performance can places undue burden on victims who have to lead the investigations.[325]

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[319] Bernath, T. & Gahongayire, L., above note 172.

[320] VanDenBerg, E. J. & Grealish, M., above note 165.

[321] This thesis focuses on assessing how multi-sector service integration contributes to meeting human rights state obligations to address sexual violence. While victim-centredness is a critical part of making integrated services effective, I do not frame the analysis in terms of theories on victim autonomy which is a diverse discipline. For discussions on victim autonomy see Mordini, N. M. Mandatory State Interventions for Domestic Abuse Cases: An Examination of the Effects on Victim Safety and Autonomy. (2003) 52 *Drake Law Review* 295; Van Cleave, R. A. 'Rape and the Querela in Italy: False protection of victim agency' (2006) 13 Mich. J. Gender & L. 273; Little, J. 'A. Balancing Accountability and Victim Autonomy at the International Criminal Court.' (2006) 38. *Geo. J. Int'l L.,* 363.

[322] Walklate, S. *Victimology*: *The Victim and the Criminal Justice Process* (2013).

[323] The Constitution of Kenya, above note 29; The Constitution of South Africa, above note 29.

[324] Smythe, D., above note 36.

[325] Ibid.

The World Health Organisation has issued guidelines that contain parameters on what sexual violence survivor-centred integration looks like.[326] These guidelines stipulate that women who have experienced violence should be treated with dignity and respect and be given comprehensive information to choose their own course of action. In addition, privacy and confidentiality should be ensured, and no victim should be discriminated against, not on any grounds.

Operating from these guidelines, Zapata et al highlight practical guidelines for effective service integration based on a program integrating HIV and sexual and reproductive health services in Epako clinic, Namibia.[327] These authors highlight three key principles of what they call a person-centred integration approach: 'accessibility of services, comprehensiveness, where all services are provided in the same physical place and longitudinal services, meaning that the same service provider follows up the same clients over time.'[328] In this program, implementing a person-centred integration approach was noted to improve the quality of services by improving communication between clients and service providers and reducing waiting time. Therefore, this literature shows that to determine victim-centeredness, the critical question to ask is whether the integration model's design, nature and scope is responsive to the complex needs of victims, as well as victims' rights.[329]

2.10. Conclusion and Summary of Literature Gaps

Multi-sector responses that integrate sexual violence services are lauded as an effective implementation approach to address sexual violence. In this chapter I have discussed the existing literature on integration and multi-sector approaches in the field of violence against women specifically, and complemented it with broader literatures on collaboration and integrated service delivery. There is a dearth of studies from low- and middle-income countries and most studies are in the form of project evaluations. With the health systems literature dominating the violence against women integration discourse, one main gap is that

[326] WHO, *A clinical handbook*: *Health care for women subjected to intimate partner violence or sexual violence*, 2014; WHO, *A manual for health managers: Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence,* 2017.
[327] Zapata, T., Foster, N. & Campuzano, P. et al., above note 134.
[328] Ibid.
[329] Vetten, L., above note 53.

a lot of the directly relevant studies have focused on intra-sector collaboration within the health sector. As a result, there is limited interrogation of multi-sector collaboration across legal, health and psychosocial service sectors.

In addition, existing literatures have evaluated integration models based on isolated, specific components of integration such as health, counselling services, and criminal justice responses. Therefore, beyond measuring sector-specific outcomes and indicators, the literature on sexual violence service integration does not adequately speak to complexities of multi-sector service integration. Furthermore, most studies have assessed integration by focusing on narrowly conceived outcome indicators such as immediate health or legal (criminal justice) outcomes, without linking these to victims' perspectives on long-term care and support through these integrated service systems. Two relevant theories emerge from the literature, collaboration theory and nodal governance. These theories prove useful in understanding integration and unpacking the complex relationships and operations of multi-sector collaborations.

This study will contribute towards addressing the gaps in literature by building the evidence base for understanding the context of integration models in low-resource settings within parts of Africa through case studies of Kenya and South Africa. In addition, this study takes a comprehensive perspective of assessing integration models across multi-sector lines covering health, legal and psychosocial services, using a feminist human rights framework based on states' responsibility to address sexual violence. Through this broader perspective, I move away from assessing immediate, separate, sector-specific outcome indicators in evaluating multi-sector collaborations. Using the two theories, I seek to understand how the integration models in Kenya and South Africa, as case studies, produce certain orientations that may either be contributing towards or impeding the fulfilment of the state's obligations to prevent and respond adequately to sexual violence against women.

CHAPTER 3

STATE ACCOUNTABILITY FOR SEXUAL VIOLENCE: DUE DILIGENCE AS THE MERGING OF HUMAN RIGHTS AND FEMINIST DISCOURSES

3.1. Introduction

> *Women are typically raped, not by governments, but by what are called individual men. The government just does nothing about it. This may be tantamount to being raped by the State, but it is legally seen as 'private', therefore as not a human rights violation.*[330]

Feminists challenge mainstream human rights because these are structured to keep women's experiences of violence, often perpetrated by individuals in the 'private' sphere, outside the scope of state accountability.[331] Kenya's Gender Based Violence Recovery Centres (GBVRCs) and South Africa's Thuthuzela Care Centres (TCCs), integrate support services for women who experience sexual violence as part of everyday hostilities, often perpetrated by private individuals.

These service centres support single, individualised, seemingly isolated and normalised rape cases, which have been termed, quite accurately, as 'everyday rape'.[332] Developments on states' accountability for sexual violence have largely focused on conflict-related sexual violence, often under the understanding of rape as a weapon of war.[333] These integration centres support sexual violence cases occurring during so-called 'peace time', that is, outside of the exceptional circumstances of war or armed conflict.[334]

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[330]MacKinnon, C., 'Rape, Genocide, and Women's Human Rights' (1994) 17 *Harvard Women's Law Journal* 5 at 14.

[331] I use 'private' in quotes to signify that this false dichotomy has been dismantled, though it persists; Manjoo, R., UN Doc A/HRC/26/38/2014 above note 210, para 63. For a critique of the dichotomy see Charlesworth. H, Chinkin, C. & Wright. S., 'Feminist approaches to international law' (1991) 85 *American Journal of International Law* 613.

[332] Edwards, A., 'Everyday rape: international human rights law and violence against women in peacetime' in McGlynn, C. & Munro, E. V. eds., *Rethinking Rape Law* (2010) 92.

[333] Ayiera critiques how human rights systems have separated sexual violence in conflict from 'the continuum within which a culture of violence breeds, congeals and becomes an intricate part of the social fabric'.
Ayiera, E., 'Sexual violence in conflict: A problematic international discourse' (2010) 14 *Feminist Africa* 7 at 15.

[334] Ibid at 92. Quotations are used because peace does not mean the absence of hostilities. Feminist scholars have cautioned against seeing violence in armed conflict as exceptional or as more atrocious than normalised

My interest here is to use these service integration centres as case studies to join debates on state accountability for sexual violence prevention and response.[335] In this thesis I aim to assess how the TCCs and GBVRCs contribute to the fulfilment of human rights-based state obligations to prevent and effectively respond to sexual violence against women. I locate my analysis of service integration within the purview of state responsibility to address violence against women so as to assess how current state implementation efforts are meeting the needs and fulfilling the rights of women victims.

The premise from which I depart is that violence against women occurs on a continuum, through conflict, post-conflict, displacement situations and in so-called peace time.[336] This continuum approach has 'increasingly blurred the distinction between violence against women perpetrated in the public and the private spheres'.[337] The concept of due diligence in human rights law extends state accountability beyond the limits of state acts or omissions to cover human rights violations perpetrated by non-state actors or private individuals.[338] The application of due diligence in the context of violence against women has challenged the public/private dichotomy that historically kept women's experiences of violence outside of mainstream human rights law and discourse.[339] This means that states can be held responsible for failing to prevent or effectively respond to sexual violence perpetrated by private individuals.

The central argument in this chapter is that by extending state accountability to everyday sexual violence cases, the human rights due diligence concept signifies a point of intersection where human rights law finally meets a long-standing feminist agenda to politicize the

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violence against women by private individuals that continues unabated in places and times where there is no war; MacKinnon. C., *Are Women Human? And other international dialogues* (2006); Manjoo, R., 'Violence against women as a barrier to the realisation of human rights and the effective exercise of citizenship' (2016) 112 *Feminist Review* 11. These scholars argue that women are at greatest risk of violence perpetrated by intimate partners. Therefore, even in times of so-called peace the situation of women does not really change.

[335] Bunch, C., 'The intolerable status quo: Violence against women and girls' 1997 *The Progress of Nations* 41; Youngs. G., 'Private pain/public peace: Women's rights as human rights and Amnesty International's report on violence against women' (2003) 28 *Journal of Women in Culture and Society* 1209.

[336] Manjoo, R., 'The Continuum of Violence against Women and the Challenges of Effective Redress' (2012) 1 *International Human Rights Law Review* 1.

[337] Ibid at 27.

[338] Manjoo, R., above note 84.

[339] Ertürk, Y., above note 77.

personal.[340] The convergence of these two discourses is important because it creates a useful analytical lens to assess state implementation efforts aimed at addressing violence against women. Using this feminist human rights perspective facilitates the centrality of victims' needs and rights in assessing service integration models, while highlighting the need for state responsibility to establish sustainable and effective sexual violence interventions.

3.2. The Need for State Accountability: Violence against Women as a De-Prioritized Agenda in Human Rights Law

Violence against women is a violation of human rights, an impediment to personal, societal and national development and an inhibitor to women's realisation of other human rights.[341] However, states continue to de-prioritise efforts to recognize violence against women and to eradicate this widespread atrocity.[342] While several global human rights instruments have consistently articulated that violence against women is a human rights violation,[343] there is yet to be an international normative, binding state obligation to eliminate violence against women.[344]

The reluctance of states to affirm the universal right of women to be free from all forms of violence speaks to the global disregard for women's human rights, while privileging protections for violations that men are likely to encounter.[345] For example, states are very clear about obligations with regard to violations that men are likely to be encounter, such as

[340] Oloka-Onyango, J. & Tamale, S., 'The personal is political, or why women's rights are indeed human rights: An African perspective on international feminism' 1995 *Human Rights Quarterly* 691; Bourke, J., *Rape: A History from 1860 to the Present* (2015); Romany, C., 'State responsibility goes private: a feminist critique of the public/private distinction in international human rights law' in Cook, R.J. ed., *Human Rights of Women: national and international perspectives* (1994) 85.

[341] Manjoo, R., UN Doc A/HRC/26/38/2014, above note 210.

[342] Manjoo, R., 'Widespread and pervasive violation of our human rights' (2016) 72 *Socialist Lawyer* 36.

[343] UN General Assembly, *Declaration on the Elimination of Violence against Women*, 20 December 1993, A/RES/48/104, arts 1, 2; UN Committee on the Elimination of Discrimination Against Women*: General Recommendation No. 12, Violence Against Women*, 1989; UN Committee on the Elimination of Discrimination Against Women, *General Recommendation No. 19: Violence against women*, 1992; CEDAW General Recommendation No. 35, above note 89

[344] Manjoo, R. & Jones, J., eds., *The Legal Protection of Women from Violence: Normative Gaps in International Law*. Routledge (2018).

[345] Qureshi, S., 'The recognition of violence against women as a violation of human rights in the United Nations system' (2013) 28 *South Asian Studies* 187.

torture at the hands of state officials.[346] Conversely, states and international stakeholders remain conflicted about the need to have clear obligations for violations that women are more likely to experience, such as sexual violence by an intimate partner.[347] Even where binding state obligations exist at regional[348] or national levels, as in the case with both Kenya[349] and South Africa,[350] there is still a gap between the rights on paper and the lived realities of women.[351] States fail to dedicate resources, design sustainable strategies to prevent and respond to violence against women through enactment of policies and guidelines without costed action plans for implementation.[352]

McKinnon argues that this disregard of state responsibility to eradicate violence against women as a human rights violation should not be surprising.[353] Human rights law, like law generally, is based on a 'male model on what it means to be human'.[354] As such, available protections in human rights law are abstract, in a way that 'is difficult to relate to women's lived experiences.[355] In this way mainstream human rights discourse signifies yet another example of how gendered legal systems fail to take into account considerations for different

[346] Benninger-Budel uses the example of the prohibition of torture, a widely accepted *jus cogens* to describe the disproportionate application of human rights to women's experiences of violence which are still not recognised in international law. Benninger-Budel, C., ed., *Due Diligence and Its Application to Protect Women from Violence*. 2008 at 4; UN General Assembly, *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, 10 December 1984, United Nations, Treaty Series, vol. 1465, 85.

[347] The current SRVAW mandate holder recently solicited global opinion from states, civil society and other human rights actors as to the necessity of a global violence against women treaty. The views were divided, with some noting the need to fill the normative gap and others calling for implementation of existing frameworks as they are. She concludes that there is no need for addressing the normative gap and calls for more co-operation between regional and global systems. Šimonović, D., *Report of the Special Rapporteur on violence against women, its causes and consequences on the adequacy of the international legal framework on violence against women*, UN Doc A/72/134, 2017.

[348] African Union, *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa*, 11 July 2003 arts 1-3. This Protocol prohibits unwanted or forced sex and requires law enforcement organs at all levels to effectively enforce the law in protecting women and girls from sexual violence.

[349] Constitution of Kenya 2010 arts 2(5), (6). As a monist state, the international and regional human rights instruments relevant to sexual violence ratified by Kenya, bind the state, and need not be domesticated first for them to have effect.

[350] South Africa has ratified and is signatory to both the CEDAW and the African Women's Protocol.

[351] Buiten. D. & Naidoo. K., 'Framing the problem of rape in South Africa: Gender, race, class and state histories.' (2016) 64 *Current Sociology* at 535; Kimuna, R. S., Tenkorang, Y. E., Dyamba, K.Y. et al., above note 143.

[352] Manjoo, R., above note 84.

[353] MacKinnon, C., above note 330.

[354] Qureshi, S., 'Feminist analysis of human rights law' (2012) 19 *Journal of Political Studies* 41 at 43; Bunch, C., 'Women's rights as human rights: Toward a re-vision of human rights' (1990) 12 *Human Rights Quarterly* 486.

[355] Knop, K., 'Restatements: feminism and state sovereignty in international law' 1993 *Transnat'l L. & Contemp. Probs* 293.

women's needs and voices. When institutions are structured without regard to the different characteristics of women, implementation efforts will fail to effectively respond to women's needs and protect their rights.

3.3. Challenging the Public/Private Divide: Feminist Critique of Mainstream Human Rights

Feminists have challenged the western liberal construction of the state that creates the public/private divide. This is an 'artificial separation of an individual's life into two spheres; the domestic sphere, to which women are mostly restricted in theory and practice, and spaces outside the home, which are men's domain.' [356] The gendered nature of this distinction keeps the private or personal space outside of state intervention, distinguished from the public or political space for which the state is held accountable.[357] The principle of state non-intervention in the private sphere consolidates male hegemony by limiting state intervention, which reinforces gendered power imbalances.[358] Such reinforced gender inequalities serve to invisibilise women's lived experiences and limit their full participation in public life as equal citizens.[359]

As a result of this invisibility, the private sphere has served as the 'locus of women's oppression, from forces that are no less powerful than the state itself, as they operate in the immediate context of the person concerned'.[360] Women's experiences of violence perpetrated by private individuals in the so called 'private sphere' are not sporadic or isolated acts, but are a pattern of systemic oppression resulting from intersecting inequalities for which states should be held accountable.[361] Corrigan argues that it is especially important to use a feminist analysis in understanding the operations of sexual violence service centres. This is because it reveals that the experiences of individual victims are 'not new, unique, specific,

[356] Qureshi, S., above note 354 at 45.
[357] Ibid.
[358] Qureshi, S., above note 354.
[359] Ibid.
[360] Ibid at 45; Engle, K., 'International human rights and feminism: When discourses meet' (1991) 13 *Michigan Journal of International Law* 517.
[361] Manjoo, R., above note 84.

and personal, rather they are illustrative of broader patterns' of systemic social, political and economic inequalities.[362]

In African settings, which operate within plural legal systems, the 'personal is political' mantra only tells half of the story.[363] Tamale argues that to complete the picture for women in developing countries in Africa, another slogan should be added; 'the local is global'.[364] There are international geopolitical forces that impact an African state, compounding the experience of a woman victim of violence with 'axes beyond androgyny'.[365] For example, in a context where most sexual violence victims have no access to basic health care, housing, economic empowerment, or social services, a sexual violence victim needs as immediate a recourse to her basic socio-economic rights, as her civil and political rights. Therefore, the human rights law tradition of categorising rights through rankings of civil and political rights as first generation rights then socio-economic rights as second generation, with the latter falling lower in priority, is impractical and irrelevant for African women.[366]

In addition, the communitarian relations of the African context mean that the 'private' sphere is wide in scope, made up of several members of the extended family, making it more of a

[362] Corrigan, R., 'Why feminist theory matters for feminist practice: The case of rape response' (2014) 10(2) *Politics & Gender* 280 at 283. Feminism is a diverse school of thought. Unlike Corrigan and other feminist scholars mentioned in this chapters, some feminist sects do not have similar views and approach the issue of violence against women differently. For example, some feminists focus more on victim autonomy and choice in defining what justice is to victims at a personal level. I am interested in the (general) strand of feminist analysis that politicises seemingly isolated sexual violence cases perpetrated by individual men, because I want to link it to state responsibility. My interest here is to show that in resource constrained settings there are intersecting structural and systemic inequalities which compound the experiences and choices of individual victims. Where support services are not accessible or available it is less a question of choice as one of limited options. In these contexts, lack of access to basic services make the question of victim choice and autonomy inadvertently linked to structural gaps and challenges. By using due diligence as a feminist analysis, I am interested in how the systemic level challenges impact these individual choices of/challenges faced by sexual violence victims at these service centres.

[363] Oloka-Onyango, J. & Tamale, S., above note 340.

[364] Ibid.

[365] Ibid at 702. Tamale and others have argued that in a third world African country, what may appear as a local private space to the western mind, is compounded by frustrations and tensions set in motion by global forces of international political economy. See also Makau, M., 'Savages, Victims and Saviours: The Metaphor of Human Rights' (2001) 42 *Harvard International Law Journal* 201.

[366] Oloka-Onyango, J. & Tamale, S., above note 340.

'legion, in comparison [with] individualised western contexts.'[367] This makes it harder for women victims of violence to escape the 'private' sphere.[368]

3.4. State Responsibility to Exercise Due Diligence in Addressing Violence against Women

The due diligence standard has developed in human rights law amidst these ongoing debates challenging the utility of the persisting public/private divide that structures relationships between citizens as rights holders and the state as duty bearer. Feminists contest the idea that state responsibility should be limited to the public domain, which is also characterised as the political domain, because it effectively keeps women's experiences of violence and other rights violations invisible.[369]

Traditionally, state responsibility for human rights violations arise only when human rights violations are occasioned by the state itself, through its agents or apparatus.[370] A long-standing exception to this rule is that states may be held accountable for violations occasioned by non-state actors, if the state fails to exercise due diligence in preventing or responding to such violations.[371] Due diligence presents a standard used to determine whether a state can be held in breach of its obligations for acts or omissions which result in human rights violations, whether occasioned by the state or private actors.[372] The due diligence standard in human rights law made its début in the *Velázquez Rodríguez vs Honduras* case.[373] Here the Inter-American Court of Human Rights held the state of Honduras, which was a State party to the American Convention, responsible for forced disappearance occasioned by non-state actors because,

> [a]n illegal act which violates human rights, and which is directly not imputable to a State can lead to international responsibility of the State not because the act itself,

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[367] Ibid at 702.
[368] Qureshi, S., above note 354.
[369] Oloka-Onyango, J. & Tamale, S., above note 340.
[370] Draft Articles on Responsibility of States for Internationally Wrongful Acts, General Commentary, *Yearbook of the International Law Commission, 200,* vol. II (Part Two), para. 77.
[371] Manjoo, R., above note 84.
[372] Bourke-Martignoni, J., 'The history and development of the due diligence standard in international law and its role in the protection of women against violence' in Benninger-Budel. C., ed., *Due diligence and its application to protect women from Violence* (2008) 47.
[373] *Velázquez Rodríguez v Honduras* Inter-Am.Ct.H.R. (Ser. C) No. 4 (1988).

but because of the lack of *due diligence* to prevent the violation or to respond to it as required by the Convention.[374]

This court stated that Honduras had failed to prevent the violations, to investigate, identify and punish the perpetrators and to provide adequate compensation to the victims.[375]

The due diligence standard is important in the context of violence against women because a greater part of women's experiences of violence are perpetrated by private individuals in the so-called private sphere. This standard represents a gradual shift in the context of state responsibility, from a narrow state-centric view, limited to active state conduct, to broader interpretations of obligations which include state responsibility for violations by private individuals.[376] More recent developments of due diligence have clarified the content, scope and meaning of this standard, which extends the limits of state responsibility to violence against women by private individuals.[377]

The mandate of the UN Special Rapporteur on violence against women, its causes and consequences (SRVAW) has been instrumental in both challenging the fallacious public/private divide and in developing the content of the due diligence standard.[378] The SRVAW mandate has defined due diligence as a tool which can be used by rights-holders to hold states accountable for prevention, protection, prosecution, punishment and provision of adequate redress for violence against women, whether perpetrated by the state or private actors.[379] Former SRVAW Ertürk describes due diligence as a measuring stick to assess

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[374] Ibid at 172.
[375] Ibid.
[376] Hessbruegge, J.A., 'The Historical development of the doctrines of attribution and due diligence in international law' (2003) 36 *NYU Journal of International law and Policy* 265; Benninger-Budel, C., above note 346
[377] Ertürk, Y., above note 77.
[378] The first Special Rapporteur of violence against women Radhika Coomaraswamy, started discussions on due diligence when in her report on domestic violence, she highlighted considerations for determining compliance with due diligence. See Coomaraswamy, R., 'Integration of the human rights of women and the gender perspective, Violence against women in the family' *Report of the Special Rapporteur on violence against women, its causes and consequences*, submitted in accordance with Commission on Human Rights resolution 1995/85, E/CN.4/1999/68. Subsequent mandate holders further developed these discussions, see Ertürk, Y., above note 77; Manjoo, R., above note 210.
[379] Ibid.

whether a state is meeting its obligations to eradicate violence against women in a meaningful and concrete way.[380]

This tool provides an assessment framework for ascertaining what constitutes effective fulfilment of state obligations. [381] Therefore, due diligence has the potential to give express guidance to a state on what it means to fulfil human rights obligations to address violence against women.[382] Due diligence pushes traditional boundaries of state accountability 'to generate greater state obligations to deal with violence against women at the private sphere.'[383]

State responsibility to exercise due diligence has been enshrined subsequently in international and regional human rights normative standards. For example, in 1993, the Declaration on Elimination of all forms of Violence against Women (DEVAW) was adopted. Although it is a non-binding, soft law, it urges State Parties to exercise due diligence to prevent, investigate and punish acts of violence against women, whether perpetrated by the state or non-state actors.[384] The 1994 UN Resolution establishing the mandate of the SRVAW recognizes the duty of State Parties to exercise due diligence to prevent, investigate, punish and provide access to just and effective remedies acts of violence against women.[385] The 1995 Beijing Platform for Action[386] and the UN Human Rights Council 2011 Resolution, which calls for accelerated efforts to eliminate violence against women,[387] equally acknowledge this standard.

More recently, The CEDAW Committee's General Recommendation 35 reiterated that 'due diligence is an obligation that underpins the Convention as a whole'.[388] This recommendation

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[380] Ibid.
[381] Qureshi. S., 'The emergence/extension of due diligence standard to assess the state response towards violence against women/domestic violence' (2013) 28 *South Asian Studies* 55.
[382]Manjoo, R., UN Doc A/HRC/26/38/2014, above note 210.
[383] Clapham, A., *Human Rights Obligations of Non-State Actors* (2006) at 17.
[384] UN DEVAW, A/RES/48/104, above note 343.
[385] UN Resolution E/CN.4/RES/1994/45, 1994, para 2.
[386] UN, *Beijing Declaration and Platform of Action, adopted at the Fourth World Conference on Women*, 1995, para 1245b.
[387] UN Human Rights Council Res 17/11, *Accelerating Efforts to Eliminate All forms of Violence against Women*, 17th June 2011, para 24.
[388] CEDAW General Recommendation No. 35, above note 89, para 24b.

stipulates that State Parties to the Convention have a responsibility to 'prevent as well as to investigate, prosecute, punish and provide reparation for acts or omissions by non-State actors which result in gender-based violence against women.' [389]

As noted earlier, these global instruments are soft law, and create no binding state obligations. The effect of due diligence in the absence of an actual normative binding state obligation is limited, since due diligence is itself not a state obligation, but an extension of state responsibility applications.[390] Some scholars have questioned whether due diligence adds any value as a legal standard, given that there are already existing positive state obligations within human rights law. For instance, Holtomaat argues that 'to act with due diligence' remains a vague and general obligation which can be dangerous and less effective against much more precise state obligations in international documents.[391] She states that 'The concept seems to suggest that as long as the State argues that it has done *something* this is enough, no matter whether the internationally *agreed result* has been achieved in due time or not.'[392]

Such arguments expose the limits of due diligence as a standard that states can violate with little consequence. Without binding state obligations to address violence against women, due diligence itself becomes difficult to monitor and implement. However, where there are binding state obligations in this regard, due diligence has more potency to assess whether a state is meeting its obligations to eradicate violence against women in a concrete way. This is because thus far, the frame of due diligence has been used to develop clearer parameters on what state responsibility to address violence against women practically means.

Within regional normative standards, the Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence requires Convention Parties to refrain from any act of violence against women and also to take necessary measures to

[389] Ibid.
[390] Manjoo, R. & Jones, J., eds., above note 344.
[391] Holtmaat, R. 'Preventing violence against women: The due diligence standard with respect to the obligation to Banish Gender Stereotypes on the Grounds of Article 5 (a) of the CEDAW Convention' In *Due Diligence and Its Application to Protect Women from Violence* (2008) 63.
[392] Ibid.

exercise due diligence including providing reparations.[393] Similarly, the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women requires State Parties to 'apply due diligence to prevent investigate and impose penalties for violence against women'.[394]

In Africa, the Maputo Protocol obliges States to enact and enforce laws that prohibit violence against women whether perpetrated in the public or private sphere, and to adopt legislative, social, administrative, and socio-economic measures to eradicate violence against women.[395] The Protocol obliges States to prevent violence against women and punish perpetrators. It further requires States to ensure access to services and reparations to victims of violence against women. Former SRVAW Manjoo has argued that a collective reading of these provisions of the Protocol does lead to the conclusion that it enshrines the due diligence principle.[396]

In addition, jurisprudence from international and regional courts and quasi-judicial tribunals continue to clarify what state responsibility to exercise due diligence entails. For example, these bodies have consistently articulated that due diligence requires states to address systemic impunity that normalise violence against women, which impedes access to justice. For instance, the CEDAW Committee has argued that State Parties should address systemic deficiencies in the legal and institutional mechanisms in order to fulfil the obligation to protect human rights, especially the right to security of the person.[397] This Committee also articulated that a state fails in its obligation to protect, if legal protections are poorly enforced by the police and prosecutors.[398] Similarly, the Inter-American Court of Human Rights found that 'generalised patterns of negligence in prosecuting violence against women violates state responsibility to protect, prosecute and prevent.[399] The African Commission has also found

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[393] Council of Europe, *The Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence*, November 2014, CETS No. 210.
[394] Organization of American States (OAS), *Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women ("Convention of Belem do Para")*, 27 U.S.T. 3301, 1438 U.N.T.S. 63, June 1994.
[395] African Women's Protocol, above note 348, article 2(4) b
[396] Manjoo, R., above note 84.
[397] *A.T. v Hungary* Communication No. 2/2003, UN Doc. CEDAW/C/32/D/2/2003 (2005).
[398] *María da Penha v Brazil* Case 12.051, Report 54/01, OEA/Ser.L/V/II.111 Doc. 20 (2000).
[399] *María da Penha v Brazil Case 12.051, Report 54/01, OEA/Ser.L/V/II.111 Doc. 20 (2000),* para 55 and 56.

that States fail in the duty to prevent when 'it tolerates a situation where private persons or groups act freely and with impunity in violation of the rights guaranteed under the Charter.'[400]

3.5. Due Diligence in Kenya's And South Africa's Laws and Courts

Both Kenya's and South Africa's Constitution enshrine progressive bill of rights that provide for the right to be free from violence from public and private sources, in addition to other rights.[401] These include the right to equality and non-discrimination on the basis of sex or gender, the right to human dignity, right to human life and freedom and security of the person.[402] South Africa has been described as having the most developed due diligence jurisprudence regarding violence against women.[403] The most notable case in which due diligence was articulated is *Carmichele v. Minister of Safety and Security & Another*.[404] The Court held that the State has a duty to protect women from sexual violence,[405] 'including protecting women against the invasion of their fundamental rights by perpetrators of violent crime.'[406] The Court stated that the State has a duty to put in place appropriate measures to prevent the violation of her constitutional rights.

In other cases, South African courts have considered the duty of States in the context of negligence by State officers failing to prevent direct or indirect harm leading to claims of damages, framed generally as against constitutional standards.[407] For example, in *Van Eeden v Minister of Safety and Security*[408] the Court found that the State has a duty of care which it failed to exercise towards a young woman who was sexually assaulted and raped by a serial rapist who escaped police custody. Likewise, in *Suzette Irene Nelson v Minister of Safety and Security & Another*,[409] the Court found the State liable for failure to protect citizens from all

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[400]Equality Now and Ethiopian Women Lawyers Association (EWLA) v. Federal Republic of Ethiopia, Communication 341/2007, 16th November 2015, African Commission on Human and Peoples' Rights, para 25.
[401]Constitution of Kenya, above note 29; Constitution of South Africa, above note 29.
[402]Ibid.
[403] Abdul Aziz, Z. & Moussa, J., above note 47.
[404] *Carmichele v Minister of Safety and Security and another 2001 CCT 48/00 ZACC 22; 2001 (4) SA 938 (CC); 2001 (10) BCLR 995 (CC).*
[405] Ibid.
[406] Ibid, para 62
[407] Smythe, D., 'South Africa's response to domestic violence' in Benninger-Budel. C., ed., *Due Diligence and Its Application to Protect Women from Violence* (2008) 157.
[408] *Van Eeden v Minister of Safety and Security* 2001 (4) SA 646 (T).
[409] *Suzette Irene Nelson v Minister of Safety and Security & another* 2006 ZANCHS 88.

forms of violence when State authorities failed to withdraw a firearm from a husband who later shot his wife. The Court stated that the victim would not have been injured had the State acted diligently.

In Kenya, the due diligence principle has been applied in one judgement, more recently, the *C.K. (A Child) & 11 Others v Commissioner of Police/Inspector-General of the National Police Service & 2 Others*.[410] In this 2013 class action suit, 160 girls brought a public interest case against the State for failing to investigate and punish sexual violations perpetrated against them. The Court found the State responsible for systemic violence, due to the failure to ensure proper and effective investigation and prosecution, which created a 'climate of impunity for the commission sexual offences'.[411] The State was held responsible for the physical and psychological harms inflicted on the victims by private individuals 'because of the laxity and failure to take prompt and positive action to deter' the sexual violations.[412]

3.6. The Feminist Human Rights Lens: Due Diligence as the Merging of Discourses

The due diligence standard presents an opportunity for the intersection between the seemingly neutral and objective human rights law, and a long-standing feminist agenda to politicise women's personal experiences of violence.[413] The potency of due diligence, for feminists, goes beyond its value as a legal construct that expands state responsibility to actions of non-state actors. It is and indeed has been used as a political tool to contest the gendered public/private divide and its role in shaping the relationship between women, the state and the law.[414]

Some scholars have described this intersection of mainstream human rights and feminist discourse on violence, through due diligence, as the feminist appropriation of due

[410] *C.K. (A Child) Through Ripples International as Her Guardian and Next Friend) & 11 Others v Commissioner of Police/Inspector General of The National Police Service & 3 Others* (2013) eK petition 8 of 2012, High Court at Meru.
[411] Ibid at 10.
[412] Ibid.
[413] Romany, C., above note 340
[414]Ibid; García-Del Moral, P. & Dersnah, M., above note 78; Chinkin, C., 'A critique of the public/private dimension' (1999) 10 *European Journal of International Law* 387.

diligence.[415] Moral and Dersnah argue that women's rights advocates and feminist scholars seized 'due diligence as an opportunity to re-configure the relationship between State and its citizens.'[416] As such due diligence opens up new avenues to assess state accountability for preventing and effectively responding to everyday sexual violence against women by private individuals.

The application of due diligence to protect women from violence by private individuals took years of 'active framing efforts by transnational women's advocacy groups, using international governance structures and human rights frameworks as sites of contestation.'[417] This is because the reasoning in *Velázquez Rodríguez*, the landmark due diligence precedent, did not especially lend itself to an easy framing of state responsibility for violence against women. The forced disappearance of Mr. Rodríguez, being a man, involved human rights violations occurring in a context that is already spatially considered as public, hence already political.[418] In addition, scholars have highlighted the incongruence of the *Rodríguez* case as the seminal point of reference for due diligence, when it is almost certain that Mr Rodríguez's disappearance, alongside many others at the time, were almost certainly executed by state security forces, not non-state actors.[419]

Through subsequent jurisprudence and scholarly work feminists have 'institutionalized' an understanding of due diligence as currently applied in the context of violence against women.[420] This understanding is one that goes beyond using due diligence as a legal principle, but also as a political and sociological concept that has broad implications for understanding the relationship between human rights, citizenship, gender and violence.[421]

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[415] García-Del Moral, P. & Dersnah, M., above note 78 at 6-7. Clapham similarly describes it as a 'feminisation' process. Clapham, A., above note 383 at 17.
[416] Ibid.
[417] Ibid.
[418] Ibid.
[419] Benninger-Budel, C., above note 346.
[420] Moral & Dersnah use the word 'institutionalization' in their analysis of how feminists have re-defined due diligence and its application to mean that they have engrained a meaning of due diligence that goes beyond the formal inclusion of the words 'due diligence' in texts. This concept has been used to shift the way women relate to the state by making rights-claims that could not have been made before legitimately. For example, domestic violence now being considered a human rights violation. García-Del Moral, P. & Dersnah, M., above note 78.
[421] García-Del Moral, P. & Dersnah, M., above note 78 at 6-7.

The implication is that feminists have pushed the boundaries of human rights law on state responsibility to expose invisible forms of violence against women and girls in the private sphere. Beyond establishing state responsibility for human rights violations at the international plane, due diligence in the context of violence against women has developed to become an analysis tool, a yardstick used to assess state implementation efforts even at national levels. For example, using the human rights principle of non-discrimination, former SRVAW Ertürk argues that 'the due diligence standard requires States to use the same level of commitment in relation to prevention, investigation, punishment and provision of remedy for violence against women as they would for any other form of rights violation.'[422]

Due diligence requires states to implement programmes that acknowledge the complex needs of women victims of violence, arising from intersecting inequalities which predispose certain categories of women to increased vulnerabilities.[423] Such categories include women disadvantaged on the basis of socio-economic status, race and disability. This responsibility requires states to adopt laws and policies to ensure that all women have access to justice mechanisms that encompass both criminal and civil measures to hold offenders accountable.[424] These human rights frameworks call on states to meet the needs of victims of violence by ensuring their physical and mental health needs and safety needs and to provide effective access to adequate redress. Using this feminist human rights lens to understand multi-sector collaborations advances the literature on sexual violence service integration by adding a different analytical perspective that facilitates the centrality of victims' needs and rights in evaluating integration models.

3.7. Individual and Systemic Levels of Due Diligence Analysis

I use this feminist human rights perspective to centre the needs and rights of sexual violence victims in analysis in two main ways. On one level, I interrogate how integration models address the multiple needs of individual victims. In addition, I engage in a system level analysis to reflect on how systemic and structural flaws affect the integration models' abilities to address victim needs and rights. Former SRVAW Manjoo argues that state responsibility to

[422] Ertürk, Y., above note 77.
[423] Manjoo, R. UN Doc A/HRC/23/49/2013, above note 80, para 20.
[424] Ibid, para 21.

act with due diligence should be separated and discussed through a dual lens, that is, individual and systemic due diligence.[425] Individual due diligence is concerned with the obligations that the state owes to the individual victims, including to prevent, protect, punish and provide effective remedies for each case of violence against women specifically.[426] The aim of individual level due diligence is that the state should provide support services to assist victims in rebuilding their lives and moving forward.[427] This may include providing monetary compensation and assistance to relocate. The importance of individual due diligence is that it is flexible and should be applied in a way that meets the specific needs and preferences of each victim of sexual violence. States fulfil the individual due diligence obligation of protection by providing services such as counselling, legal advice, access to shelters or a safe house, and health care.[428] The State obligations to prevent and protect, still at individual due diligence, can be fulfilled through providing education on where and how to seek help when raped, information regarding available services, and protection measures to break the cycle of violence.

In the assessment of multi-sectoral approaches, individual due diligence facilitates a reflection of how the needs and preferences of sexual violence victims are considered in shaping the orientation of service integration models. As discussed in the previous chapter, one complexity of multi-sector approaches is that there are contrasting and often competing sector ideologies and goals. In sexual violence service provision, integration models attempt to balance the differing interests of health, legal and psycho-social sectors. The pursuit of these different sector-specific mandates has the potential to eclipse or side-line the individual needs and preferences of sexual violence victims. Sexual violence service integration models would contribute towards fulfilment of individual due diligence state obligations by inquiring what victims' needs are, then facilitating a process of responding to those needs through their operations.

[425] Ibid, para 70.
[426] Ibid.
[427] Ibid.
[428] Ibid.

The second level of analysis, is systemic level due diligence, which requires states to ensure a sustainable and holistic model of addressing violence against women through transforming institutional norms and social attitudes.[429] This responsibility requires states to establish mechanisms for prevention, protection, prosecution, punishment and redress that are effective, by targeting the root causes of violence against women. [430] This level of due diligence recognizes that, while law reform and enactment of policies are important, states have a responsibility to combat structural and systemic inequalities for sustainable and effective prevention and response. This includes challenging ongoing gender discrimination, which creates an enabling environment for sexual violence and secondary victimization to continue unabated. Manjoo argues that beyond modifying legislation, a state can fulfil its systemic due diligence obligations by 'reinforcing the capacities of service providers to avoid re-victimisation in the process of seeking recourse; developing strategies, action plans and awareness-raising campaigns; holding accountable those who fail to protect and prevent, as well as those who perpetrate and adequately resourcing transformative change initiatives.'[431]

For multi-sector service integration approaches, this systemic due diligence lens facilitates an assessment of how integration models are targeting, challenging or shifting deeply rooted institutional norms. I also assess how such structural inequalities and systemic flaws affect the operations of the integration centres to compromise the model's efforts to meet victims' needs and fulfil their rights.

3.8. Conclusion

In this chapter I have argued that the state responsibility to exercise due diligence presents and opportunity where mainstream human rights intersects with the feminist agenda to politicise women's personal experiences of violence. Due diligence emerged against the backdrop of ongoing feminist debates to dismantle the public/private divide that constricts state accountability for violence against women by private individuals. These feminist debates contend that women's experiences of violence, even at the hands of private individuals in the so called 'private sphere' are not sporadic or isolated acts, but are a pattern of systemic

[429] Ibid, para 71.
[430] Ibid.
[431] Ibid.

oppression resulting from intersecting inequalities for which states should be held accountable.[432]

In the last three decades, the content of due diligence has developed to push the boundaries of mainstream human rights, re-defining parameters of states responsibility and accountability to include violations occasioned by both state and non-state actors. Accordingly, states have the responsibility to prevent and effectively respond to sexual violence against women by private individuals, occurring as part of everyday hostilities. In the context thereof, in this thesis I use due diligence as a feminist human rights lens, which is useful in assessing how state implementation efforts are contributing towards fulfilling its human rights obligations by meeting the needs and fulfilling the rights of women who experience everyday sexual violence.

[432] Ibid, para 20.

CHAPTER 4

RESEARCH DESIGN AND METHODS

4.1. Introduction

This thesis uses a qualitative case study approach to understand how Kenya's Gender Based Violence Recovery Centres (GBVRCs) and South Africa's Thuthuzela Care Centres (TCCs), comparatively, contribute to the fulfilment of human rights-based state obligations to address sexual violence against women. The GBVRCs and TCCs are integration models that integrate health, legal and psychosocial support services to facilitate holistic, multi-sectoral responses to sexual violence.

I selected the case study method because it is particularly suited for describing or evaluating interventions,[433] as well as for investigating 'why' and 'how' a phenomenon operates within its real-life context.[434] Using this approach I sought to understand how these integration models operate, through combining opinion data from interviews with different service providers, perspectives of victims who received services from these centres, and secondary data from facility records. The case study method is also useful because it allows one to maintain holistic and meaningful characteristics of a phenomenon.[435] Therefore this method was helpful in enabling me to understand integration models, which are precisely designed to facilitate a holistic response to sexual violence.

The research sites comprise of four GBVRCs in Kenya and four TCCs in South Africa, selected purposefully to represent, to the extent possible, the range of integration models in terms of structure, facilities and locality. Each research site is treated as an individual case study, analysed to understand its unique operational setting. The identified GBVRCs and TCCs with similar characteristics are categorised alongside each other to see how the different integration models respond across different service contexts and national implementation contexts. Comparison of research sites in similar settings minimizes differences which may

[433] Baxter, P. & Jack, S., 'Qualitative case study methodology: Study design and implementation for novice researchers' (2008) 13 *The Qualitative Report* 544.
[434] Yin, R.K., *Applications of Case Study Research Series* 2 ed. (2002).
[435] Yin, KR., *Case study research: Design and methods* (2003) at11.

arise from structural or contextual variations. I analyse integration models across a set of key indicators based on the framework of state responsibility to act with due diligence to prevent protect, prosecute, punish and provide redress for sexual violence against women.[436]

While this qualitative study uses diversely selected sites to give an in-depth understanding of specific sexual violence integration models in Kenya and South Africa, it does not produce generalizable findings. Nonetheless, by testing how these integration models contribute towards fulfilment of human rights-based state obligations to address sexual violence, I show how multi-sector collaborations, as a phenomenon, can be understood and interpreted.[437] In addition, from the findings I draw theoretical propositions that could be applied in legal and policy considerations on integrating sexual violence interventions in similarly situated resource-constrained settings.

4.2. Why Compare Kenya and South Africa?

Kenya and South Africa are both former British colonies that came to independence and constitutional democracies amidst conflict characterised by violent struggle.[438] Both countries face challenges related to structural and socio-economic inequalities and a vast majority of citizens, especially women, remain without access to basic services including healthcare, and access to formal justice systems.[439]

Despite the general lack of proper statistics on sexual violence, available data shows that sexual violence prevalence in both Kenya and South Africa is dire. As statistics have shown, sexual violence remains highly problematic in both Kenya and South Africa.[440] Both countries

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[436] Ertürk, Y., above note 77.

[437] Cheek argues that while generalisability as a construct is drawn from the science and mathematics fields it can have a different meaning and relevance in qualitative social science research. Relying on Talja's work Cheek concludes that findings of qualitative studies like this may not be 'generalizable as descriptions of how things are but as how a phenomenon can be seen or interpreted'. Cheek, J., 'At the margins? Discourse analysis and qualitative research' (2004) 14 *Qualitative Health Research* 1140 at 1147; Talja, S., 'Analysing qualitative interview data: The discourse analytic method' (1999) 21 *Library & Information Science Research* 459.

[438] Ogot, B.A. & Ochieng, W., *Decolonization and independence in Kenya* (1995) at 1-4; Ross, R., *A Concise History of South Africa* (2008) 75.

[439] Rogan, M., 'Gender and Multidimensional Poverty in South Africa: Applying the Global Multidimensional Poverty Index (MPI)' 2015 *Social Indicators Research* 1; Milazzo, A. & Dominique. V., *Women Left Behind? Poverty and headship in Africa*, 2015.

[440] See Chapter 1, above section 1.2.

have similar and progressive legal and policy frameworks on sexual violence. Both countries have gone through sexual offences law reform processes that resulted in the adoption of sexual offences legislation.[441] These statutes,[442] as well as the Constitutions in both these countries enshrine progressive definitions, and robust protections against violence.[443] Despite existing laws, sexual violence victims in both countries face challenges when seeking recourse from the criminal justice system as described earlier. To address these challenges, both countries have adopted the multi-sectoral approach and developed multi-agency collaboration units to facilitate the integration of sexual violence interventions. [444]

While both countries are essentially employing a similar strategy, that is, multi-sector collaboration in response to sexual violence, the integration models operate differently. For instance, while South Africa's TCCs are established through a systematic state-led approach,[445] Kenya's GBVRCs are less systematically established, emerging largely 'organically' through support by different civil society organisations.[446] Therefore, while the TCCs operate upon clearly defined parameters meant to be standardised nationally, Kenya's GBVRCs are more uneven, varying in operation by context, depending on the stakeholders involved. This comparative study will enable a consideration of implications of these different approaches of operating integration models aimed at addressing a similar problem, within similar legislative and policy environments.

Perhaps the best justification for this comparison, however, is that the courts in both countries are developing a jurisprudence extending the application of state obligations to act with due diligence to address sexual violence to their national contexts. While Kenya has started developing precedent in the recent past,[447] South Africa has established what has

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[441] Onyango- Ouma, W., Ndung'u, N. & Baraza, N. et al., *The Making of the Kenya Sexual Offenses Act, Behind the Scenes*, 2006; Artz, L. & Smythe, D., above note 69.
[442] Kenya Sexual Offences Act; South Africa Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007.
[443]The Constitution of South Africa ss 12 (1) (c) (d) (e) and 12(2) (c); The Constitution of Kenya art 29 (c) (d) (f).
[444] Ibid.
[445] South Africa TCC print, above note 43.
[446] Wakahe, J.K., *Hospitals preparedness to provide comprehensive care for gender-based violence survivors in Kenya* (Master of Public Health thesis, University of Nairobi, 2010).
[447]*C.K. (A Child) & 11 Others v. Commissioner of Police/Inspector-General of the National Police Service & 2 Others*, above note 410.

been described as having one of the most developed jurisprudence on the due diligence principle.[448] Therefore, this similar jurisprudential context creates an enabling environment for assessing the effectiveness of integration models in both countries on the basis of their contribution to state responsibility to act with due diligence to prevent, protect, prosecute, punish and provide adequate redress to victims of sexual violence.

4.3. Operationalizing Measures: Due Diligence as an Assessment Framework

This research uses a feminist human rights framework premised on an understanding of the state's responsibility to act with due diligence to prevent and effectively respond to violence against women.[449] Ideologically, proponents of the due diligence approach recognize that, 'although smart partnerships between civil society organisations and the State are beneficial, and can result in innovative and successful strategies, the State should bear the ultimate responsibility for addressing sexual violence against women'.[450]

As noted in the previous chapter, due diligence in the context of state obligations to address sexual violence has developed beyond a legal concept, to be a framework of analysis that can be used to understand how a state is fulfilling its human rights obligations. Therefore, I use due diligence as an analytical framework to understand how integrated implementation approaches are working to address sexual violence in Kenya and South Africa comparatively. I rely primarily of the work by Abdul Azizi and Moussa, who in collaboration with others have developed the Due Diligence Framework on State Accountability for the Elimination of Violence against Women (2014).[451] This framework crystalizes the state obligations as articulated in regional and international human rights frameworks and creates five key pillars; the obligation to prevent, protect, prosecute, punish and provide adequate redress.

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[448] Abdul Aziz, Z. & Moussa, J., above note 47.
[449] García-Del Moral. P, & Dersnah. M., above note 78.
[450] Abdul Aziz, Z. & Moussa, J., above note 47 at 5.
[451] Ibid. The primary framework used to determine the content of these state obligations was the result of a research project involving experts across disciplines from academia, inter-governmental organisations, and women's rights organisations from 48 countries, including Kenya and South Africa, and therefore provides a good evaluation starting point.

I also use content of due diligence developed by the mandate of the UN Special Rapporteur on violence against women, its causes and consequences,[452] including applications of both individual and systemic components of due diligence.[453] While each of the components of state responsibility to exercise due diligence has broader meanings in different international and national law contexts, I have limited their scope of understanding for purposes of this study. Below I discuss the meaning and content of due diligence, from which I derived measurements that informed the questions in my interview schedules.

This methodology moves beyond previous methods used in similar existing studies, which have focused solely on how integration models meet immediate health needs or facilitate legal (criminal justice) outcomes.[454] While these highlight important factors that speak to the state's obligations to prosecute and punish, the obligations to prevent, and to provide adequate redress are often not addressed. Therefore, by using this holistic human rights framework, aim to include a broader analysis of how integration models operate in a way that facilitates or impedes realisation of these different elements of human rights-based state obligations.

4.3.1. Prevention

The obligation to prevent requires states to take all means that are legal, political, administrative and cultural to ensure sexual violence is considered as being illegal, leading to the punishment of perpetrators and redress for victims.[455] Effective prevention of sexual violence targets the underlying causes of violence against women.[456] Feminist theorists argue that violence against women is rooted in gender inequality.[457] Empirical studies confirm that, while there are multiple factors that cause violence against women at various levels of the social ecology, they remain underpinned by unequal gendered power relations.[458] Therefore,

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[452] Ertürk, Y., UN Doc. E/CN 4/200661, above note 77.
[453] Manjoo, R., UN Doc A/HRC/23/49/2013, above note 80, para 20.
[454]Artz, L., Smythe, D. & Leggett, T., above note 50; Keesbury, J., Onyango-Ouma, W., Undie, C. et al., above note 56.
[455] Manjoo, R., above note 80, para 15.
[456] Henry, N. & Powell, A., eds., *Preventing Sexual Violence: Interdisciplinary Approaches to Overcoming a Rape Culture* (2014) at 214; Ellsberg, M., Arango, D.J., Morton, M. et al., above note 235.
[457] Butler, J. & Scott, J.W., eds., *Feminists theorize the political* (2013); Cahill, A.J., 'Foucault, rape, and the construction of the feminine body' (2000) 15 *Hypatia* 43.
[458] Ellsberg, M., Arango, D. J., Morton, M. et al., above note 235.

effective prevention requires the modification of attitudes, norms and behaviours and of social and cultural practices that normalize, propagate and justify sexual violence.[459] Effective prevention activities include sustained education and awareness-raising campaigns. Community mobilization and participatory projects that engage multiple stakeholders show promising results in resource-poor settings.[460] Modifying discriminatory laws, policies, customs and practices is important because laws and social norms can be mutually reinforcing in the fight against violence against women.[461] However, legal reforms are only effective when accompanied with other multi-layered and multi-levelled approaches that target the underlying drivers.[462] This includes for instance changing systems of socio-economic inequalities, which predispose women to sexual violence.[463]

In a multi-sectoral approach, certain sectors will take the lead in prevention work more than others. Social services agencies and organizations working on women's economic empowerment may for instance take the lead in primary prevention, with the health and legal sector participating through collaboration.[464] The health sector plays a main role in secondary and tertiary prevention through early identification, which reduces the likelihood of further sexual violence.[465] Prevention is particularly difficult to monitor or evaluate because it involves the changing of attitudes and mind-sets, and relies in some measure on the behaviour of perpetrators. These kinds of analyses are outside the scope of this dissertation. However, GBVRCs have a role to play in conducting activities that contribute to prevention. My research considers how the research sites incorporate such activities in their work. I also investigate whether the research sites collaborate with other stakeholders who implement prevention strategies.

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[459] Ibid.

[460] Kyegombe, N., Abramsky, T., Devries, K. M. et al., 'The impact of SASA! A community mobilization intervention, on reported HIV-related risk behaviours and relationship dynamics in Kampala, Uganda' (2014) 17 *Journal of the International AIDS Society* 19232.

[461] Hughes, C., *Legislative wins, broken promises Gaps in implementation of laws on violence against women and girls*, 2017.

[462] Lundgren, R. & Amin, A., 'Addressing intimate partner violence and sexual violence among adolescents: Emerging evidence of effectiveness' (2015) 56 Journal *of Adolescent Health* 42.

[463] Mikton, C., Butchart, A. & Dahlberg, L. et al., 'Global status report on violence prevention 2014' (2015) 21 *Injury Prevention* 213; Banyard, V., Elizabethe, P. & Moynihan, M.M., 'Bystander education: Bringing a broader community perspective to sexual violence prevention' (2004) 32 *Journal of community psychology* 61.

[464] Garcia-Moreno, C., above note 132.

[465] Ibid

Prevention programs require institutionalized, sustained strategies with a broad scope, targeting local communities, workplaces, schools, faith-based institutions, among other stakeholders[466] Sustained strategies include National Action Plans and state-supported institutional mechanisms, such as inter-agency collaboration models. Competent enforcement of laws deter sexual violence by sending a message to society that sexual violence will not be tolerated by the state.[467]

4.3.2. Protection

The State obligation to protect requires keeping victims safe from harm, avoiding recurrence and ensuring that victims receive adequate support services in a timely manner.[468] These support services include shelters, hotlines, protection orders, legal services, social welfare services, health services, including medical treatment and completion of medico-legal documentation. In this sense, protection is a form of secondary prevention.[469] To ensure protection, first responders should respond urgently to sexual violence cases to reduce the risk of harm to the victim, for example by arresting the perpetrator. Therefore, health service providers, police officers, social workers, community members should be trained on identifying sexual violence and what steps to take when they are presented with a case.[470] The training should also address attitudes of service providers, who often compromise protection by relying on myths and stereotypes that cause secondary victimization of sexual violence victims.

At a systemic level, this requirement means that the state has an obligation to target the underlying causes of sexual violence against women, which is rooted in gender inequality. This is affected by eliminating prejudicial practices and stereotypes that subjugate women.

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[466] Abdul Aziz, Z. & Moussa, J., above note 47.
[467] Ohayi, R., Ezugwu, E., Chigbu, C. et al., 'Prevalence and pattern of rape among girls and women attending Enugu State University Teaching Hospital, southeast Nigeria' (2015) 130.1 *International Journal of Gynecology & Obstetrics* 10.
[468] CEDAW General Recommendation No. 19, above note 343.
[469] Cornelius, T. L. & Resseguie, N., 'Primary and secondary prevention programs for dating violence: A review of the literature' (2007) 12 *Aggression and Violent Behaviour* 364; Ellsberg, M., Arango, D.J., Morton, M. et al., note above 235.
[470] Abdul Aziz, Z. & Moussa, J., above note 47.

Recognizing that the root cause of violence against women is gender inequality, as it intersects with multiple other layers of social, political economic and cultural inequalities, due diligence here requires a direct effort that overlaps with and targets prevention of violence against women.

In assessing how the GBVRC's and TCCs contribute to protection, I investigate what services are provided on site and how other services that ensure protection are integrated accordingly to support victims. I consider the number of sexual violence cases reported through the research sites, and, where needed, how referrals for essential services are made and followed up. I assess what mechanisms are in place to ensure timely identification and referral of a sexual violence case to the required service provider, which increases chances of protecting the victim. I assess how the research sites assist in ensuring the victim has relevant information regarding her case, such as information related to bail. Here I also asked victims in support groups questions related to their experience with the research sites and how it affected their safety, including safety from recidivism or re-occurrence of violence.

4.3.3. Prosecution

The obligation to prosecute requires the state to not only prosecute, but to also ensure that prosecution is as non-traumatic as possible for victims of sexual violence.[471] Effective prosecution depends on thorough and proper investigation to establish the facts related to a sexual violence case. Investigation and prosecution should be prompt and impartial. Integrated service provision can enhance prosecution by reducing turn-around time and alleviating secondary victimization,[472] and ensuring adequate collection and preservation of evidence.[473] The state obligation to prosecute requires prosecutorial discretion to be exercised reasonably by, for example, not dismissing repetitive sexual violence perpetrated by an intimate partner as normal. Effective prosecution also safeguards the privacy and confidentiality of victims, who may be at risk for such pursuit.[474] Collaboration with

[471] Ibid.
[472] Artz, L., Smythe, D. & Leggett, T., above note 50.
[473] Ajema, C., Rogena, E., Muchela, H. et al., *Standards required in maintaining the chain of evidence in the context of post rape care services: Findings of a study conducted in Kenya*, 2009.
[474] Abdul Aziz, Z. & Moussa, J., above note 47.

specialized prosecutors and/or specialized courts provides a more conducive environment for victims of sexual violence to go through the prosecution process with less secondary victimization.[475]

Integration approaches can contribute to prosecution through efficient medico-legal documentation, and collection and preservation of forensic evidence to ensure successful conviction. In this way integration contributes to holding a perpetrator accountable. To assess this, I sought to collect data on how cases received at the research sites are investigated and prosecuted. I also investigate the process that the sexual violence cases go through from reporting at the integration centre to prosecution, to note the role played by the multi-sector collaboration approaches. I explore what linkages exist between the integration centres, the prosecutors and the courts and whether the integration models facilitate any collaborative training to police and prosecutors to build capacity and strengthen referral networks.

4.3.4. Punishment

The obligation to punish requires states to have not just criminal sanctions, but civil, administrative or other penalties for sexual violence perpetrators.[476] As a minimum, punishment requires ensuring negative consequences to the perpetrator for committing the offence.[477] This obligation, as it relates to retribution, is about holding perpetrators accountable and punishing them for an offence committed. Through certainty of punishment the state sends the message that sexual violence is not tolerated. This relates to both specific deterrence, which deters the individual perpetrator and general deterrence, aimed to deter the public from future offending.[478] Deterrence also relates to the obligation to prevent because a punishment regime that meets the due diligence principle is one that considers the multiple structural and systemic inequalities that cause violence against women.[479]

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[475] Ministerial Advisory Task Team on the Adjudication of Sexual Offence (MATTSO), *Report on the Re-Establishment of Sexual Offences Courts*, August 2013, Department of Justice and Constitutional Development, South Africa.
[476] Abdul Aziz, Z. & Moussa, J., above note 47.
[477] Ibid.
[478] South African Law Commission, *Discussion Paper 91 (Project 82) Sentencing (A New Sentencing Framework),* 2000.
[479] Manjoo, R., above note 336.

A comprehensive approach to punishment for sexual violence also brings into focus rehabilitation and restorative justice. Given the systemic inequalities that plague post-colonial, post-conflict African states, sexual violence perpetration needs to be understood within broader security debates and the socio-economic challenges that underpin it. Restorative justice emphasizes victim participation in the criminal justice system and offender accountability through reparations and rehabilitation rather than solely through incarceration.[480]

I assess how the multi-sector service integration models contribute to the fulfilment of the obligation to punish by asking which punishment options are available. I analyse how the integration models ensure a victim is aware of all the options available while supporting her to seek recourse. For instance, while the option of punishing the perpetrator through criminal prosecution may be availed to the victim at the research site, she may not be informed of or be supported to pursue a civil or administrative remedy. Through multi-sectoral collaboration, a platform is created where the victim can be informed of other options. I also assess how integration centres facilitate victim's participation in the process of punishing the perpetrator through collaborations with criminal justice system actors. This includes assessing collaborations with correctional services, which can enable victim participation in sentencing procedures, even post-trial processes such as parole. In addition, I investigate how evidence collected and preserved may increase chances of criminal punishment.

4.3.5. Provision of Adequate Redress

The obligation to provide adequate redress requires states to avail adequate remedy and reparations to victims of sexual violence, including compensation to address the harm or loss suffered by them.[481] Reparation aims to mitigate the effects of sexual violence. Depending on the victim, redress could be monetary compensation, sanctioning or punishing the perpetrator, an apology or other symbolic reparations. Reparations should be proportionate to the harm suffered. This is dependent on the facts of the case and gravity of the violation. Victims who decide to pursue compensation should be protected from further risks of such

[480] Ibid.
[481] Abdul Aziz, Z. & Moussa, J., above note 47.

pursuit.[482] In addition, even when compensation orders are granted it is often difficult to enforce them. The state therefore has an obligation to ensure that the compensation is recovered from the perpetrator.

Reparation is important because it can be a transformative tool that addresses the root causes of violence against women through restitution.[483] The conventional criminal justice system peripheries the victim of rape, as it focuses on the state and the offender in the prosecution process. The notion of victim's rights in criminal justice is nascent in law. However, the development of victim's rights as a research area tries to imagine new ways of re-positioning and including the needs of victims in criminal justice.[484] Therefore, advocates of victims' rights and some feminist work have problematized the culture of the criminal justice system that equates the recognition of harm to a prison sentence. For example, Claire McGlyn argues that this narrow perspective totally obscures the possibility of securing justice for sexual violence through any other means.[485]

As in punishment, sexual violence service integration centres can contribute to adequate redress by creating a platform where the victim can be informed of, and linked to all the redress options available to her. Depending on the recourse she decides to pursue, integration can improve her experience and access to proper investigation, successful prosecution and successful recovery of reparations. Under this component, I investigate what forms of redress are available to victims of sexual violence, which they pursue, what challenges the victims face when seeking and recovering reparations and how the integration centres assists victims of sexual violence to pursue the recourse they choose.

4.4. Describing the Research Sites

The research sites are multi-agency centres providing integrated services for survivors of sexual violence. These centres, usually located in public health facilities, aim to integrate legal,

[482] Ibid.
[483] Spies, A., 'Perpetuating Harm: The Sentencing of Rape Offenders II Challenging the Real Rape myth' (2016) *SALJ* 389; Manjoo, R., above note 70;
[484] Terblanche, S., 'Twenty years of constitutional court judgments: What lessons are there about sentencing?' (2017). 20.1 *Potchefstroom Electronic Law Journal*.
[485] McGlynn, C., 'Feminism, rape and the search for justice' (2011) 31 *Oxford Journal Legal Studies* 825.

health, and psycho-social support services for victims of gender-based violence seeking recourse. This study relies on qualitative data from eight such sites, four GBVRCs in Kenya and four TCCs in South Africa. I categorised the research sites into three categories containing the centres based on similarity of characteristics in terms of structure, facilities and locality. The sites in each category are discussed in relation to the comparable pair within its own cluster as well as across implementation contexts to understand each country's integration approach.

The first category comprises of well facilitated centres located in urban settings. This category also includes the first models to be established in the respective countries. Including these pioneer models allows for a historical perspective of the models' development and reflections on how things have changed since conceptualisation. These are South Africa's Heideveld TCC that was previously based at GF Jooste hospital, and Kenya's Kenyatta National Hospital GBVRC. I also included Karl Bremer TCC under this category because it has been described as one of the most effective, well-resourced and busiest TCCs operating near optimum potential in South Africa.

The last centre under this first category is Kenya's Nairobi Women's GVRC. This centre is an anomaly in comparison to all other centres because it is a non-profit centre based in a private hospital, while the rest are based in public hospitals operated mainly through state machinery. Nonetheless, I included this centre because it is described as a centre of excellence in sexual violence service integration in Kenya, a centre which trains and capacitates other integration centres in the country and beyond.[486] Interview participants also referred to the GVRC as a critical partner in the referral networks, but also as a platform for referral itself, as provider of integrated services.[487]

Nairobi Women's GVRC was also the first (private) integration centre to be established in Kenya. There is no privately owned TCC to act as direct comparator for the Nairobi Women's

[486] Nairobi Women's GVRC accessed at http://gvrc.or.ke/ on 4th April 2018.
[487] During the research sites mapping exercise in Kenya the GVRC was mentioned as critical in understanding the story of integration in Kenya. This was especially by service providers at the GBVRC in Provincial General Hospital Nakuru, and KNH GBVRC.

GVRC. However, being well facilitated and based in an urban setting, the similarities of services offered, of facilities and structure can be drawn between the GVRC and other centres in this category, which are useful for general analysis. For instance, both Karl Bremer and the GVRC were described as the centres of excellence and busiest centres due to their locations, therefore I compare what it means to integrate sexual violence services under such busy circumstances.

The second category has reasonably facilitated centres located in peri-urban settings. These centres are based in provincial, secondary-level hospitals with wide geographical coverage. I selected Kenya's Provincial General Hospital Nakuru (PGH Nakuru GBVRC) and Worcester TCC for this category because they fit the above description and hence allow for understanding of the complexities of integrating at provincial level. These models represent the next level of scale up, when integration models begin to be established outside main cities or beyond urban centres. These models are also referral centres for cases presenting at lower-level facilities, which may mean they receive a large amount of cases but without same level of capacity as the well-resourced, urban centres in the first category.

The third category comprises of centres in rural settings, within district level, primary health facilities providing basic integrated services. I selected Kenya's Kitale District Hospital GBVRC and Wesfleur TCC because these centres serve cases arising from rural areas facing similar challenges of access and follow up due to infrastructural challenges. They are also among the most recent to be established in the respective countries and are almost entirely funded by international NGOs, despite being based in public state hospitals. This category is also informative in terms of how such centres partner with community-based organisations and resources to overcome structural challenges.

A notable factor that emerged from the fieldwork was that, while integration models in Kenya and South Africa were matched based on structure, facilities and locality, the tier or level of health facility was not a relevant factor in the categorising process, as I had expected.[488] While

[488] As a consistent theme in the integration literature, the quality analysis of integration models is analysed on the basis of the tier or level of health facilities in which integration models are based, that is tertiary, secondary or primary health care levels. See for example: Colombini, M., Mayhew, S. & Watts C., above note 63. However,

in Kenya the difference between the well-resourced sites and the least capacitated sites correlates with the tier of the facility, this was not the case in South Africa. It was clear during the mapping exercise that in South Africa, even centres considered to be well resourced could be based in a district level, primary health care facility. This is because the TCC strategy is to provide services closest to the communities that need them most, integrated into primary health care. The table below provides a summary of the research sites selected for each category.

that approach did not auger well in the context of this comparative study, due to the differing strategies of establishing the integration centres, which is not determined by these health systems tires.

TABLE 1: SUMMARY TABLE OF RESEARCH SITES

Category	Brief description	Kenya's research site	South Africa's research site
1	Well facilitated, Located in Urban setting Inception centres in the country	Kenyatta National Hospital GBVRC	Karl Bremer TCC Heideveld TCC (former GF Jooste)
		Nairobi Women's GVRC (in a private hospital)	None
2	Reasonably well facilitated Located in peri-urban setting Based in Provincial /regional hospital	Nakuru PGH GBVRC	Worcester TCC
3	Basic services located in rural setting/ or supporting rural communities Based in District hospital	Kitale District GBVRC	Atlantis- Wesfleur TCC

4.5. Data Collection Methods

The research uses largely qualitative data collected through interviews with different service providers and victims of sexual violence who have been supported through these centres. I also reviewed records and statistics at the research sites where these were available to understand case flow and referral patterns.

4.5.1. Interviews with Service Providers

I conducted semi-structured interviews with 65 service providers and key informants, 29 in Kenya and 36 in South Africa.[489] I chose interviews as a method because it allows for collection of in-depth, open ended, detailed information, which was useful in understanding operations of the service integration centres.[490] I interviewed at least one staff member at management level at the centres to get a sense of overall functioning, aims and objectives of the GBVRC or TCC. I then interviewed service providers for each of the services being provided on-site at the GBVRC and TCC, including for example, a counsellor, a medical practitioner, a police officer, legal officer, case manager, social worker, paralegal and victim assistant officer as relevant to each centre, to note and include different perspectives.

Where services were integrated through referral to a local NGO, I gathered as much information from the staff at the GBVRC on the kind of partnership and services provided by the other stakeholders. Where accessible, I conducted follow up interviews with these NGOs. Where the services were integrated by referral to state agencies such as law enforcement and prosecutors, I assessed from the GBVRC/TCC staff, the modalities of this referral, including consistency of follow up, existence of standard operating protocols, guidelines or other policy frameworks, and specialised mechanisms to facilitate referral of sexual violence cases. Where there was systematic collaboration between a research site and the specific government agency, such as police station/officer or prosecutor I interviewed these state agents, where available. I conducted the interviews myself. Each interview was approximately 45 minutes, I used audio recording and an interview schedule (Appendix C). I obtained

[489] See Appendix H for descriptive details of interviewees.

[490] Boyce, C. & Neale, P., *Conducting in-depth interviews: A guide for designing and conducting in-depth interviews for evaluation input*, 2006.

consent by first providing and information sheet (Appendix A) with details of the research and explaining to participants what the study is about, in advance. This process also confirmed what the purpose of the study is, how the data will be used, that participation is voluntary without financial reward and permission was sought to use audio recording. Participants confirmed consent by siging a consent form (Appendix B) with the understanding that they can withdraw consent at any time. I provided my contacts and the contacts of the academic institutions I was affiliated with to participants, in case of any further questions and follow up.

4.5.2. Reviewing Facility Records

I reviewed the collated case records at the GBVRCs and TCC for the past 12 months from the time of data collection to find out how many sexual violence cases the GBVRC/TCC received and what proportion of those that are received are investigated, prosecuted and how many resulted in convictions, and what kinds of sentences were issued. This was to enable an analysis of the role of integration approach in facilitating investigation, prosecution and certain forms of punishment and redress. Data from these records is used alongside national statistics on sexual violence incidence and prevalence. Some centres had more detailed records than others and different types of statistical data were captured at different centres. I used a data collection instrument with specific indicators for each of the state obligations to act with due diligence, as a guide for collecting this data (Appendix G).

4.5.3. Group Interviews with Victims

I conducted group interviews with sexual violence victims who have formerly been supported through the centres to understand how the integration models enhanced their service experience. The rationale for conducting group interviews was because there was an existing platform, victims support groups, that met once a month at the centres. This was a safe space which was led by victims and facilitated by counsellors and social workers as a follow up strategy for identifying any victim needs and finding ways to meet them. The participants felt comfortable speaking about service provision in this collective space, so I used this method to avoid the pressure of individual one on one interviews.

Interviewing victims was particularly crucial in informing the research sites' contribution to the obligation to protect as described in the previous chapter. This obligation involves ensuring issues such as privacy and confidentiality of services, victim safety, timely response and services that do not result in secondary victimisation. I conducted four group discussions for each of the four GBVRCs in Kenya. Each group discussion had between 5-12 volunteering participants. I spoke to a total of 34 victims of sexual violence in Kenya. The discussions lasted about one hour, and I used an interview schedule (Appendix D) as a guide for the discussions. I conducted the interviews myself, but in two of the four centres, the discussions were also facilitated by counsellors who sat in the meetings. The process of obtaining consent involved providing information to victims (Appendix E) clarifying purpose and how the data will be used. Thereafter, as with service providers, each participant confirmed consent having understood they could withdraw at any time, that it was voluntary (Appendix F). In South Africa I did not have access to victims supported through the TCCs in the same way as I did with the GBVRCs. The main reason was due to a lack of mechanisms to maintain contact with victims after first contact at the TCCs. I discuss this issue in more detail under the study limitations section in this chapter.

4.5.4. Observation

I collected data by use of observation when I went to the TCCs and GBVRCs, by taking time to systematically observe the centres physical structures and the activities, and documenting notes for each center. I used these notes as part of the qualitative data that was coded and analysed thematically.

4.6. Ethical Considerations

The greatest potential risk involved collecting data from sexual violence victims supported through the centres support groups. Victims of sexual violence may be affected emotionally and psychologically when talking about information from their traumatic experience. Therefore, when selecting participants, I worked with counsellors and the social workers at the centres to identify research participants. As a criterion for selection, victims with pending cases in court and recently reported cases, or cases under emergency response were excluded. With the help of these centres' staff we invited previously supported victims who, on a voluntary basis, self-identified as being in good emotional and physical state to

participate in the research. These inclusion/ exclusion criteria were applied for ethical reasons to prevent re-traumatisation.

As a researcher, I recognised both the vulnerabilities and resilience of victims of sexual violence including their willingness to participate in research and tell their own stories. Relying on feminist interview methodology, I used the discussions to reduce the hierarchy of interviewer–interviewee by engaging in mutual dialogue.[491] Questions did not ask victims to talk about their sexual violence incidence, but rather focused on their service experience at the research sites. In addition, sexual violence victims are often willing to speak of their experiences when presented with the opportunity to inform research seeking to improve service provision for the common good.[492] Trauma counsellors at the research sites were invited to participate in the discussion sessions to create a safe and familiar space. Including counsellors ensured that there was capacity within the session to mitigate any situations that may arise related to past trauma. However, in all the four discussions, no such traumatic situations arose.

Another ethical issue was around disclosure of victim's information. Such disclosure can result in victims' stigma and re-victimization. Complete anonymity could not be ensured because the discussions were conducted through face-to-face interaction. To address these ethical concerns, I ensured confidentiality and privacy by using anonymous identifiers in documenting the data to avoid disclosure or traceability of the information collected to specific participants. There were no questions on the details of specific sexual violence incident experiences, or the events that gave rise to the incident. I avoided specificity by use of general language and anonymous identifiers in the write up. Files from the discussions were stored in a password protected cloud storage facility accessible only by the researcher. In addition, the confidentiality concerns that arise from a group discussion setting were ameliorated since the participants are from the centres victim support groups, and therefore were already familiar with each other and their stories

[491] Campbell, R., Adams, A., Wasco, S. et al., 'What has it been like for you to talk with me today?" the impact of participating in interview research on rape survivors' (2010) 16 *Violence Against Women* 60.
[492] Ibid.

Interviews with staff at the research sites did not pose any significant risk to participants since information collected was regarding their work as employees of the organizations they represent. One anticipated risk was that some service providers could hold different opinions to what would probably be expected of them. In such instances, such an unpopular opinion may be frowned upon by colleagues among other stakeholders. To avoid this, I conducted separate interviews with the service providers to ensure privacy and confidentiality. As was the case with victim information discussed above, I ensured confidentiality for these interviews by using anonymous identifiers to report the data and stored files in password protected cloud storage.

4.7. Negotiating Access to Research Sites and Participants

As a bi-country comparative study involving multiple sectors, my experience of negotiating access was marred with significant access challenges in both Kenya and South Africa. The process involved getting several ethics clearances and approvals from Research Ethics Committees, administrative bodies, state officials, NGOs and other gate keepers. In addition, access to the research sites, structurally speaking, did not always mean access to the participants that I sought.[493] This meant that there were layered levels at which I had to negotiate access, even within one institution or agency. The process was characterized by aspects of both formal and informal processes, conversations, partnerships and referrals that sometimes came down to personalized opinions regarding the value of my study as perceived by different stakeholders.

Since the integration centres, the research sites for this study are multi-agency units involving multiple sectors responding to violence against women, permission from multiple sectors and agencies was required. For instance, to access the TCCs in South Africa I needed to get ethics clearance and access from the National Prosecution Authority (NPA), Department of Health (DoH) and Department of Social Development (DSD), each with their own clearance and ethics review processes. This was in addition to two University of Cape Town research ethics

[493] For instance, in South Africa, access to the TCCs did not mean having access to victims who had received support services from the TCCs. Despite obtaining all requisite ethics clearances, negotiations with supporting NGOs to access survivors to incorporate their perspectives into the study were not successful. I reflect more on this lack of TCCs victims' voices under the section on study limitations.

clearances from the Law Faculty and Faculty of Health Sciences. In Kenya one main ethics clearance (from University of Nairobi, Kenyatta National Hospital REC) was validated for all sectors and centres in the country. However, I needed to negotiate access with county level local government administration or management regarding each sector/agency involved at the GBVRCs. That includes for instance the County Commissioners of Health and officers in charge of police stations. I obtained six formal clearances from research ethics committees as listed below:

i. UCT Law Faculty Research Ethics Committee Ref: L33-2015
ii. UCT Faculty of Health Sciences Research Ethics Committee REF: 833/2016
iii. Western Cape Government Department of Health Research Ethics Clearance REF: WC_2016RP36_648. Including individual ethics clearances for Wesfleur Hospital, Karl Bremer Hospital, Heideveld CDC and Worcester Hospital.
iv. Western Cape Government Department of Social Development Research Ethics Committee clearance REF: 12/1/2/4
v. Kenyatta National Hospital-University of Nairobi Ethics and Research Committee (KNH-UoN ERC) clearance REF: KNH-ERC/A/149. P37/01/2016
vi. Kenya Nakuru County Commissioner for Health Research Ethics Clearance, 08/01/16.

4.8. Data Quality Control

The data quality was ensured through non-extrapolation of data beyond the content of raw information received at the interviews. In addition, simplification in the process of transcription was avoided as it results in loss of information. Most the Kenyan interviews were conducted either fully or partially in Swahili. To ensure quality control of the data, the interviews were first transcribed and analysed in the original language in which the interview was conducted. After this first process, the transcripts were then translated into English, leaving specific quotations in Swahili where necessary to capture opinions that could not be translated and relay the same meaning or intensity. Transcriptions were also checked against recordings for inconsistencies. I, as the interviewer, also periodically reflected on my understanding of participants during interviews to check for accuracy of interpretation.

4.9. Data Analysis

The study focused on collecting qualitative data from frontline service providers and recipients of services at the research sites. This data was analysed thematically based on the framework of state responsibility to exercise due diligence as described in the operationalisation of concepts and measures above. Data analysis for this study was an ongoing process from the beginning of the field work phase when data collection started. Reflecting on the literature upon which the conceptual framework is anchored, the analysis involved a cyclic process of reading, considering themes that emerged from the data, reducing the data to manageable forms, displaying the data and interpreting the data.[494] The interviews were transcribed and then analysed. To develop the themes, I first read all the transcripts and did the first round of coding the data. Using this cyclic process, I began to cluster emerging themes based on how they related to each other to form the main themes into chapters. I constantly deliberated the codes with my supervisors and did reliability checks in this iterative process of reflection. NVivo software for qualitative data analysis was used to manage the interview data and display it, which assisted in the analysis, and interpretation.

4.10. Study Limitations

The research sites in this study include a wide range of integration models in Kenya and South Africa, but as case studies, the findings are not generalizable. Regarding South Africa's TCCs, all the TCCs selected were based in the Western Cape to control for potential differences in regional or provincial policy implementation landscapes. The limitation of this approach, however is that there is no context for sites in other provinces. For example, the rural setting in the Western Cape selected for this study may not fit a different rural setting site that would easily be comparable to a rural setting in Kenya or even elsewhere in South Africa. The findings show that while this rural site fits the description of study characteristics under the rural category, i.e., serving a widely rural population, this site benefits from more facilities and infrastructure, since the Western Cape is one of the better resourced provinces in South Africa.

[494] Miles, M., Huberman, M. & Saldana, J., *Qualitative data analysis: An expanded sourcebook* (1994); Ulin, P. Robinson, E. & Tolley, E., 'Qualitative methods: A field guide for applied research in sexual and reproductive health' (2002) 19.1 *Family Health International* 62.

However, findings of this study will raise pertinent considerations for integration models in low-resource settings that may be relevant in other similarly situated settings. Similarly, it may be difficult to generalise results of in-depth interviews because each may be unique or specific. In-depth interviews however, provide valuable information for program evaluations, especially when supplementing other methods of data collection.[495] Interviewing victims to determine the effectiveness of the integration models has limitations because victims may have a skewed perception based of their expectations which may be at odds with the integration model's objectives. To mitigate this limitation, I triangulate this data with other perspectives from service providers at the research sites and other stakeholders as well as with other data sources.

Another limitation of the study is the general lack of proper statistical data on prevalence of sexual violence and number cases that are reported, investigated and prosecuted to completion. Some research sites did not have well-kept or updated records collated for the last 12 months, or records collated in terms of the required indicators, such as number of cases investigated, prosecuted or that resulted in conviction. I mitigate this by using available national statistics published by state agencies to the extent that they will be relevant, and data from other available studies. Another limitation related to data collected is that, while the study is considering sexual violence against women and girls, victims under 18 were not interviewed due to ethical concerns regarding interviews with child victims. Therefore, the voices of girls will be absent from the analysis of victim experiences. Where available, care givers of the girl child victims were invited to the group discussions and thus to some extent the experiences of the child victims is included.

A significant limitation of this study is that it does not incorporate voices of South Africa's TCC victims in the same way as it includes perspectives of victims in Kenya's GBVRCs. While I spoke to a total of 34 victims in Kenya, I did not have access to TCC victims in South Africa. This is partly because TCCs, being conceptualised as an emergency centre offering containment services, had limited mechanisms for maintaining contact with victims after first point of

[495] Boyce, C. & Neale, P., above note 490.

contact. Access to TCC victims could not be negotiated through the NPA, the lead agency, because the NPA cases were *sub judice*, falling outside my research selection criteria.[496]

There are limitations in terms of measuring certain constructs. Evaluating the number of prevention activities a centre conducted will not show what impact the prevention activities had. This research does not focus on impact but rather on how the work or activities of these centres contributes towards fulfilment of state obligations to address sexual violence. Other measurement constructs, such as delay of services, victim safety, and secondary victimization may also be difficult to determine. Sexual violence victims experience varying emotions such as fear, stress and anxiety, which although caused partly by these factors may also affect their perceptions. Perceptions of victims and service providers may also vary due to differing interests. I mitigate these by recognizing the diversity of victim needs and desires. I also probed and focused on the consequences resulting from the delay of services or secondary victimization such as whether the case was dropped from the system, recidivism or loss of memory regarding the incident.[497]

4.11. Conclusion

In this chapter I have described the research design and methods used in this thesis. I briefly set out the conceptual framework, described my research sites and their classification for purposes of comparative analysis. I described data collection methods and research participants, ethical considerations that arose and how I ameliorated them. I also reflected on my experience of negotiating access to the research sites, challenges of conducting research on multisector approaches and limitations of the study.

[496] As explained in section 4.6 above, I excluded recently reported cases and cases pending in court.
[497] Laxminarayan, M., 'Measuring crime victims' pathways to justice: Developing indicators for costs and quality of access to justice' (2010) 23 *Acta Criminologica* 61.

CHAPTER 5

DESCRIBING THE LANDSCAPE AND FEATURES OF SEXUAL VIOLENCE SERVICE INTEGRATION MODELS IN KENYA AND SOUTH AFRICA

5.1. Introduction

The aim of this chapter is to reveal the different approaches used to integrate sexual violence services through case studies of Kenya's integration model, Gender Based Violence Recovery Centres (GBVRCs and South Africa's model, the Thuthuzela Care Centres (TCCs). These comparative case studies show that service integration operates within complex multi-sector collaborations, inclined towards producing certain outcomes as priorities over others.

I describe the landscape and salient features of these integration models by presenting findings from the study of eight integration centres, four GBVRCs in Kenya and four TCCs in South Africa. I consider variations and similarities emerging within each country context and across both countries, with reference to different geographical and resource implementation contexts, that is, rural, peri-urban, and urban settings.

This chapter shows that South Africa's TCCs and Kenya's GBVRCs implement different collaboration systems, with variations influenced by geographical contexts based on available resources and location, which determine how services are integrated across sectors. South Africa's TCCs operate a multi-sector approach, negotiated and governed at high-levels of national policy, which formalises integration at institutional levels. As such, there are systematic linkages between teams of multi-disciplinary service providers operating at the local district levels. The key features of South Africa's TCC model show that it facilitates integration fundamentally through linkages between the health sector and the criminal justice system, with the central aim of increasing conviction rates. In this regard the TCCs exhibit strong linkages in the provision of crisis counselling services, medical examination, police investigation and prosecution, with limited focus on comprehensive health care, including psychosocial support.

On the other hand, Kenya's integration centres are independently established, and operate practice-emergent models shaped and governed by different collaboration partnerships comprising donors, non-governmental organisations (NGOs) and state agencies, mainly within the health sector. Despite the absence of a national strategy or policy, these practice-emergent models in Kenya show significant congruence in their integration approaches. The key features of the GBVRCs reveal that they facilitate integration by primarily strengthening comprehensive health care and psychosocial support to improve health outcomes for victims. In this regard the GBVRCs exhibit strong linkages between health services and psychosocial support, including long-term support services, but with limited focus on legal and justice sector responses.

This chapter is divided into three broad sections. I begin with a description of the centres themselves, in terms of their physical as well as operational structures that function to integrate sexual violence services in different ways. I then describe the key features of the service integration approaches emerging in each country context. Following the analysis of each country context, I compare service integration in both countries based on the geographical and resource settings.

The comparison shows that in both countries multi-disciplinary teams of service providers do collaborate to protect sexual violence victims, but are constrained by human resource and infrastructural gaps, lack of training and limited options for referral to additional support services. While centres in urban areas are better resourced, they are the busiest centres, meaning available capacities and resources are spread too thin. In peri-urban settings, the centres struggle to use available resources because of the wide provincial jurisdictions that they cover. Centres in rural settings are the most resource constrained, especially in terms of personnel because they are the least busy centres. Here questions about the utility of implementing integration centres in remote regions, given their low uptake of services is raised, in contrast with the idea that investing in rural centres increases access to services that are otherwise not available.

5.2. Why Structure and Location Matters: Describing the Integration Centers

The GBVRCs and TCCs are service centres that operate multi-sector responses combining health, legal and psychosocial support services to generate a more effective response to sexual violence. Physically, these centres are located within health facilities, either inside the actual hospital buildings or as separate structures adjacent to the main hospital buildings.[498] Each centre has different rooms for different services being provided. While well-resourced centres have more space, more rooms, the less resourced centres combine or sequence the provision of some services within the limited available space.[499] For example, the better resourced centres have separate rooms for different services, such as counselling, social worker referral services, and consultation rooms for nurses or legal officers. Conversely, in under-resourced centres, due to limited space, the nurse's consultation room was often also used for counselling services and client registration purposes. In Kenya all the four GBVRCs are structured differently, despite having basic common features,[500] while South Africa's TCC have a fairly standardised structure according to the TCC blueprint.[501]

5.2.1. Fostering an Ethos of Safety, Comfort and Warmth to Protect Victims

An important feature of the integration centres is that they aim to create safe spaces for victims who have experienced sexual violence. In their mandates, integration models in Kenya and South Africa emphasize the need to protect sexual violence victims through prioritizing safety and comfort for victims of gender-based violence seeking services and recourse. The blueprint for South Africa's TCCs explains that '*Thuthuzela'* the Xhosa word for 'comfort' is realised in the establishment of the TCCs, and its ethos is described as follows:

> The word comfort awakens feelings of warmth, freedom from emotional and physical concerns, safety, and security, being pampered and cared for and above all, reinforcing dignity, hope and positive expectations.[502]

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[498] Fieldwork notes documenting observational data collected during research visits to the eight integration centres in Kenya and South Africa between 10th January 2016 and 31st March 2017.
[499] Ibid.
[500] Common structural features of the GBVRCs include a reception and waiting area, counselling room, nurse consultation room, medical examination room, laboratory, social workers' office and recovery room.
[501] Structural facilities of a TCC ideally include private ablutions with shower and toilet, private room for calming clients, children's room, receptions with waiting area, counselling office(s), SAPS office for statement taking, VAO office, nurse's consultation room, medical examination room, NGO office for counselling, storage and filing room.
[502] South Africa TCC Blueprint, above note 43.

Similarly, while Kenya's GBVRCs exist independently without such a national strategy or blue print, the national guidelines on comprehensive management of sexual violence requires that integrated services should 'reassure the victims of safety within a trusting environment.'[503] Similarly Kenya's multi-sectoral standard operating procedures is based on principles of facilitating effective referrals, and highlights victim safety as one of the important guiding principles.[504]

In practice this approach of facilitating service integration through the creation of safe spaces to protect victims was common in both countries. Walking into most of these centres, I observed and appreciated the effort taken in making the spaces welcoming and warm. Bright rooms, flowers, mats, table cloths and chairs, sometimes couches, happy cartoons on walls, pillows and decorations in warmly coloured open sitting spaces, gave a positively different feel compared to the dull, haunted atmosphere in the rest of the hospital spaces.[505]

South Africa's TCCs also provided comfort packs.[506] To some participants this was a way of 'restoring someone's dignity',[507] saying to the victim, we care, and we support you. One participant explained that providing showers and comfort packs to victims is a core component of the service because 'sometimes we take their (victims') underwear as evidence, and then we give them a clean new one, because maybe they were raped early hours in the morning, just imagine, all those hours sitting without taking a wash'.[508] Others emphasized that the comfort pack was not a gift but simply the provision of basic things that a victim may need; as one participant said, 'it's clear for us it's not a gift, you're not getting a gift for being raped. It's something to provide just for your immediate needs'. [509]

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[503]Kenya Sexual Violence National Guidelines, above note 4 at 3.
[504]Kenya Task Force on the Implementation of the Sexual Offence Act, *Multi-sector Standard Operating Procedures*, 2013.
[505]Fieldwork notes documenting observational data collected during research visits to the eight integration centres in Kenya and South Africa between 10th January 2016 and 31st March 2017.
[506] Comport packs are beautifully wrapped bags containing toiletries, such as underwear, deodorant, toothpaste and brush, and in some cases, a change of clothes, given to the victim to use after the victim has showered following the medical examination. Packs for children also had toys and snacks.
[507] Interview with forensic medical officer SA.B.2 on 27th March 2017.
[508] Interview with nurse SA.B.2 on 26th March 2017.
[509]Interview with social worker SA.A.2 on 1st November 2016.

In both countries, the role of first responders was especially noted as being crucial for setting the tone through containment counselling and creating trust with victims before being referred for other services. [510] One GBVRC counsellor noted that 'when the survivor comes, we are the first to create a rapport to make them feel welcome…and making them aware it was not their fault at all, that is how the relationship starts'.[511] Another counsellor at a TCC similarly said that 'we calm the victim, we make sure they feel safe, we explain the procedure to follow, what the doctor will do, and if they are comfortable with it or not, they do have a choice'.[512] These descriptions show that the integration centres contribute towards protection of sexual violence victims through creating safe spaces and a comfortable environment to provide critical post-rape care services.

5.2.2. Designated Spaces: Implications for Privacy and Stigma

In both countries all centres operate in designated spaces, set apart from mainstream service points. This intentional designation was described by several participants as a means of protection for victims through ensuring that they 'create a safe environment'[513] or 'so that the survivor is accorded that element of privacy'.[514] Separate facilities aimed to ensure privacy, confidentiality and security, to avoid secondary traumatization; as one trauma counsellor explains:

> Victims receive the services in a confidential way where there is protection and minimal noise. As you can see this block, it is separate. Everything happens inside, even counselling. So, there is minimal interruption. It is not like before they could mingle with all clients.[515]

However, the location of the centres is also important with respect to the potential stigma associated with victims being seen when entering doors clearly marked for rape services. Some sexual violence victims in Kenya explained that the location and signage of the centres

[510] First responders differed in each country context. In South Africa's TCCs, the first responders are Rape Crisis or Mosaic crisis counsellors. In Kenya it varied between social workers and nurses who are trained as trauma counsellors.
[511] Interview with counsellor KE.A.1 on 31st January 2017.
[512] Interview with counsellor SA.D.3 on 16th November 2016.
[513] Interview with counsellor SA.B.1 on 23rd March 2017.
[514] Interview with police officer KE.C.4 on 21st January 2015.
[515] Interview with trauma counsellor KE.D.2 on 3rd February 2016.

had stigmatizing effects on them. For example, one participants explained how she felt when entering the centre clearly marked as "Gender Based Violence Recovery Centre" to seek counselling services. She said, 'As I walked in, I felt like others looked at me saying 'she just looks like she has been raped'.[516]

Visibility and easy access also arose as an important consideration of the centres' locations. Some sexual violence victims mentioned that they struggled to locate the centre, especially in the big tertiary hospitals such as Kenyatta National Hospital. In a discussion with victims supported through this centre, one victim noted that, 'for me, the first time I came, I went around all over and struggled to find it (the centre)'.[517] Most of the other participants in the group discussion agreed with her, with another participant similarly stating that, 'yes, you know also, this location is quite hidden'.[518]

While all the centres were clearly marked, some signs were more prominently visible than others. For example, one GBVRC which is located in a separate physical structure adjacent to the main hospital building, is right next to the main hospital gate. [519] This centre's name is clearly marked, visible from all angles as ones enters the main gate. In contrast, another GBVRC, despite being located within the accident and emergency department, which is rather public, is located in a secluded corridor, down a few corners from the main entrance. From my observation, the latter seemed to strike a balance between visibility for easy access and privacy to avoid potential stigma for rape victims.[520]

Other descriptors, notices, or information written at the entrance to a centre were also identified as having stigmatizing effects on victims. For instance, Kenyatta National Hospital GBVRC is housed within the mental health department. On the door of this centre, there is a written list of all the services being offered therein, such as HIV counselling and mental health services. Some victims explained that this made them afraid of entering the centre due to the

[516] Group interview with sexual violence victims at Kenyatta National Hospital GBVRC on 7th June 2016.
[517] Ibid.
[518] Ibid.
[519] Fieldwork notes of observational data collected from research visit to centre KE. D on 2nd-10th February 2016.
[520] Fieldwork notes of observational data collected from research visit to centre KE.C on 15th -21st January 2016.

stigma associated with mental health and HIV. One victim said, 'Yes, for me I was concerned that other people will think I am crazy, because it says at the entrance 'Mental Health Department'.[521] In the same discussion, another victim agreed and said,

> For me I didn't know much about this place, but I feared because of what they have written at the door 'Mental Health department' and also HIV treatment… so I thought people are just looking at me saying, I must have HIV.[522]

Two of the seven participants in this discussion explained that their experiences were different, and they did not feel stigmatised by the signage or other descriptors. One of the two victims said, 'For me I was not afraid because at that time I needed help so, fear, you leave it behind'[523] Another participant similarly said, 'I did not mind…but these are things that people go through in life, so there is no problem'.[524]

Although I did not speak to victims supported through the TCCs, service providers explained that victims would sometimes express fear in seeking continued support at the TCCs because the centre's name is known for rape services. For example, one counsellor said, 'you know sometimes people do not want to come, because you know when people hear 'Thuthuzela' then they know what it is, so people will judge them and all that'.[525] This counsellor was explaining that, especially in small communities, stigma was sometimes unavoidable for victims who came to the centre. In another TCC, the service providers in collaboration with hospital management have come up with a way of avoiding this stigma for rape victims coming to the centre by using a code name for rape. The site coordinator at this centre explained:

> Rape victims usually go to casualty, but casualty people also knows the procedures, they will not use the word rape but 'OA', in Afrikaans it means *Onsedelike Aanranding*, like assault, so no one will know it is rape. Once they do come across a victim that was raped they will bring the victim in immediately to the Thuthuzela.[526]

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[521] Group interview with victims of sexual violence at Kenyatta GBVRC on 7th June 2016.
[522] Ibid.
[523] Ibid.
[524] Ibid.
[525] Interview with lead counsellor SA.D.2 on 17th November 2016.
[526] Interview with site coordinator SA.C.1 on 13th March 2017.

Similarly, another police officer thought that the separate, designated nature of the TCCs' structure minimizes potential stigma and protects victims. He said, 'in the past you(victim) would sit in the open and everybody would see…it would be embarrassing for that person, but you see now the person is seen in a secluded area, it is private, its user friendly. That person (victim) is now comfortable.'[527] Another participant also noted that the TCC structural component of having private access, through back gates leading to the centre, ensured privacy when police officers brought victims to the centre for medical examination after reporting to the station.[528] She said:

> Most of our clients who come here actually even tell you that they feel comfortable being here because nobody knows. They come in through the back gate with the police…so it is only us here when they come.[529]

This discussion shows that the location and structure of integrated sexual violence service centres matters because they have implications for the protection of victims. While separate spaces that are set apart from mainstream service points may facilitate privacy, both the location and signage of these centres may also have unintended stigmatizing effects for some victims. By acknowledging this potential for stigma, and finding creative ways to overcome it, these integration centres contribute to the protection of sexual violence victims.

5.2.3. Child-friendly Spaces and Services

I observed significant effort in all the eight centres to provide child-friendly spaces and services including having anatomical dolls for child sexual abuse treatment and therapy. In Kenya, service providers in all the four centres stressed the importance of having child-friendly services and spaces because the majority of the sexual violence cases the centres receive involve children, especially girls. In some of these centres, the facility records had well documented statistics showing this trend, while others did not have well-kept records. For example, in one of Kenya's GBVRCs with well documented records,[530] disaggregated by age

[527] Interview with police officer SA.C.2 on 15th March 2017.
[528] Two of the four TCCs I studied (SA. B and SA. D,) had this feature of separate private back gates into the health facility compound, facilitating private access to the centres.
[529] Interview with counsellor SA.D.1 on 16th November 2016.
[530] Review of facility records of centre KE. D on 8th February 2017.

and gender, statistics for the year 2014 showed that of the total 601 rape and defilement[531] cases they received, 517 (86 per cent) of the victims were children.[532] Of these children, 511 (98 per cent) were girls, and 6 (2 per cent) were boys. Similarly, in another GBVRC, of the total 467 sexual offence cases they supported in the past 12 months, 325 (69 per cent) were children, with 122 (26 per cent) of the children being under 11 years old.[533] This centre's data was not disaggregated by gender.

In South Africa, one site manager explained that the TCCs' investment in meeting the needs of child sexual abuse victims was recent, following a critique that the model's initial design - to deal with victims of 14 years and older - excluded most children in its conceptualization.[534] During the data collection at all sites, I observed that child-friendly spaces are created in the form of separate children's play rooms, which also served as spaces where investigating officers or forensic social workers carried out case consultations with the child victims of sexual abuse. These children's rooms were remarkably inviting, with several toys, life-sized teddy bears, children's games, furniture and bright paintings. Kenya's GBVRCs did not have separate children's rooms, nonetheless there was visible effort in all the four centres to create a child-friendly environment by having children's games, paintings, toys and dolls. In Kenya, the cartoon wall paintings in the GBVRCs would often be in the general areas, like the reception area[535] or corridors.[536]

5.3. Services Provided: Variations by Country, Geographical and Resource Contexts

The integration centres in both countries provide health, legal and psychosocial support services. This section gives a summary of the specific services provided by the integration centres in Kenya and South Africa. Table 2 below shows which services were provided on-site and which services were integrated through referral to external service points.

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[531] Defilement is a term used to mean rape of children, persons under 18 years, in terms of the Kenya Sexual Offences Act s.3.

[532] This centre's records categorised sexual offence cases in three categories, being rape, defilement and sodomy.

[533] Review of facility records at centre KE.C on 21st -22nd January 2016.

[534] Fieldwork notes from site mapping research visit to centre SA. B on 24th October 2016.

[535] Fieldwork notes from observation, research visit to centre KE. D on 2nd-10th February 2016.

[536] Fieldwork notes from observation, research visit to centre KE. A. on 26th January to 3rd February 2017.

From this summary table below, common features of Kenya's GBVRCs are that counselling services, and medical care services are provided on-site, with referrals for legal aid being made to specific NGOs that have established different service relationships with the centres. The GBVRCs also have partnerships with specific local police stations within their vicinity integrating services of investigating officers at the police gender desks. Medico-legal documentation is completed in two stages, first on-site at the hospital for the medical information and then completed at the police stations. Also notable is that the GBVRCs have no direct linkages to prosecutors or courts. Two of the four GBVRCs, the ones located in urban areas have linkages to specific shelter services, while the GBVRCs peri-urban and rural centres do not.

In South Africa, what is common across the four TCCs from the summary table is that crisis counselling services, medical care and forensic examination, and completion of the medico-legal documentation are provided on-site. All four TCCS centres have systematic linkages to specialised police investigation units who come to the centre on call, or bring the victims if they report to the station first. In addition, through the case manager's role, based in court, the TCC services are then linked to criminal prosecution through specialised sexual offences courts. Referrals for continued counselling services were done generally to NGOs, based on availability, and to the Department of Social Development (DSD) social workers where available.

TABLE.2. SUMMARY OF SERVICES PROVIDED IN EACH INTEGRATION CENTRE[537]

Category 1. Rural setting, based in primary level, district hospitals			
Centre	**Location**	**Services provided on site**	**Services integrated through referral**
Kitale District GRC. Kenya[538]	Both located in a separate physical structure, adjacent to main hospital building	- Emergency medical services (general health workers) - Part completion of medico-legal forms (PRC and P3 by health worker) - Trauma counselling - Continued counselling for 6 months or longer - Victim support groups for 1 year - Social worker referral and follow up	- Police report and investigation: link to one station: Kitale police gender desk. - Completion of medico-legal form (P3 form) - Pharmaceuticals and drugs - Children's department for social services, rescue & shelter services - Pro-bono lawyers by Handicap International (NGO)
Atlantis, Wesfleur TCC. South Africa[539]		- Emergency medical services (general health workers) - Completion of medico-legal forms - Statement taking (if not already done) - Bath and comfort pack after medical examination - Crisis counselling - Criminal case tracking - Referrals for continued psychosocial support	- Court support services - Victim consultation with prosecutor/legal advice - Forensic Social Worker - Specialised FCS police investigation on call - One shelter/ safe house
Category 2. Peri-urban setting, based in secondary level, provincial hospital			
Centre	**Location**	**Services provided**	**Services integrated through referral**
Nakuru Provincial General Hospital GBVRC[540]	Both located within the hospital building, at the casualty/accident and emergency department	- Emergency medical treatment - Specialised forensic examination (by Sexual Assault Nurse Examiner (SANE) nurse who fill PRC forms) - Trauma counselling - Drugs and pharmacy - Recovery room - Counselling for 6 months or longer - Victim support groups for 1 year	- Link to one police station: Nakuru central for reporting and completion of P3 forms - Legal aid by paralegals - Follow up and referral by community health workers

[537] The data presented here is collated from interviews conducted with service providers at each of the centres in the period between: January 2016 and March 2017.
[538] This Centre is based at Kitale District Hospital, a facility located slightly out of Kitale town centre, an agricultural town, in the North Rift part of Kenya.
[539] This centre is based at Wesfleur district hospital in the Western Cape, where a majority of the population served is rural, some live or work on farms. The centre is relatively new, established slightly over a year at the time of data collection. With support from the Foundation for Professional Development.
[540] This GVRC is based at the provincial general hospital in Nakuru town, capital of Nakuru County. This centre services wide jurisdiction covering most of Kenya's mid-west region and receiving referrals from across the Rift Valley province.

		- Follow up treatment and care	
Worcester TCC[541]		- Emergency medical services (general health workers) - Completion of medico-legal forms - Statement taking (if not already done) - Bath and comfort pack after medical examination - Crisis counselling - Criminal case tracking - Referrals for continued psychosocial support - Social work services for in patient clients (general hospital staff)	- Referrals to DSD for long-term counselling - Referrals to local clinics for health care follow up - Court support services - Victim consultation with prosecutor/legal advice - Specialised FCS police officers on call
Category 3. Urban settings, based in various health facility levels/tiers			
Integration centre	**Location (within hospital)**	**Services offered on-site**	**Services integrated through referral**
Kenyatta National Hospital GBVRC, Tertiary Level, specialised[542] hospital. Kenya[543]	Hosted within mental health department, inside hospital building	- Emergency medical treatment - Specialised forensic examination (Completion of PRC form) - Follow up treatment and health care - Trauma counselling - Counselling for six months - Victim support groups - Designated recovery admission ward - Social worker for referrals and follow up	- Legal aid provided by two NGOs IJM and CREAW - Direct link to one police station, gender desk: Kilimani and general referrals to other police stations, for reporting and completion of P3 forms - Shelter services - Links to economic empowerment programs
Nairobi Women's GVRC, private, specialised hospital. Kenya[544]	Located inside hospital building	- Emergency and follow up health services - Filling medico-legal documentation - Counselling for six months - Victim support groups for one year	- Referral for legal aid to IJM and CREAW - Links to economic empowerment programs

[541] This TCC is located at the Worcester regional hospital. The centre services a wide jurisdiction covering four districts Worcester, Rawsonville, Touwsrivier, and De Doorns stretching as far as approximately 100 kilometres apart. The centre was opened in October 2010.

[542] This GBVRC is located within the oldest and largest national referral public hospital in Kenya. The KNH-GBVRC is housed within the mental health department of the hospital. The GBVRC's services are available primarily to victims from Nairobi. However, being the largest referral hospital in the country, the GBVRC handles cases from all over the country.

[543] This GBVRC was Kenya's first integration models set up in 2000 in Kenyatta National Hospital, a tertiary teaching and referral hospital in Nairobi, the largest in east and central Africa. The GBVRC was established within the patient support centre of the hospital.

[544] The GVRC is a non-profit charitable trust of the Nairobi Women's hospital, which is a private hospital specializing in obstetrics and gynaecology services which seeks to provide holistic care to women and their families.

		- Case management: tracking case in criminal justice system - Social work referral services - Community awareness training and education	
Karl Bremer TCC. South Africa[545]	Separate physical structure, adjacent to main hospital building	- Emergency medical treatment - Specialised forensic examination (in-house forensic doctor) - Filling in medico-legal documentation - Containment counselling - Victim support: Referrals for counselling	- Specialised FCS police investigators on call - Case manager: victim consultation with prosecutor - Court support services
Heideveld TCC, South Africa[546]	Separate physical structure within hospital	- Emergency medical treatment - Specialised forensic examination (in-house forensic doctor) - Filling in medico-legal documentation - Containment counselling - Victim support: Referrals and follow up	- Specialised FCS police investigators on call - Case manager: victim consultation with prosecutor - Court support services

[545] Karl Bremer TCC is described as one of the busiest TCCs in South Africa averaging 131 cases per month. It is based in a based Karl Bremer Hospital classified as a district/provincially aided level facility in Belleville, a city in the greater Cape Town Metropolitan area. Vetten, L., above note 53.

[546] Heideveld TCC was moved from GF Jooste Hospital following its closure in 2014 for renovations. This was the first TCC established in South Africa and linked to the first Sexual Offences Court in Wynberg, Cape Town.

5.3.1. Who is accessing these services and what are the referral routes

The TCCs and GBVRCs seek to provide free integrated services for gender-based violence victims targeting all community members who can access them, irrespective of age, gender or other social status. Most of the TCCs are intentionally located at the district level public health facilities to ensure access to low-income communities who need the services most, at the earliest point of seeking medical services.[547] However, as will be discussed later the TCCs referral routes often begin when a case is reported to the police, after which a specialised police unit (FCS Unit) refers the case to the TCCs for forensic evidence collection and containment counselling.[548] Therefore, assess to specific TCCs is also determined by the jurisdiction of the specific FCS police units.

All but one of the Kenya's GBVRCs are also based in public hospitals. The Nairobi Women's GVRC, the exception, which is based in private facility nonetheless provides free services as well. The difference with Kenya's GBVRCs is that they are located at all facility levels from district, provincial and national level referral facilities. This means the target population accessing the regional and tertiary facilities are diverse, being referred from wide jurisdictions. In Kenya the referral routes often start at the casualty departments in the hospitals, after which victims are referred to the GBVRCs, then to the police and back to the centres for continued counselling. As will be discussed below, facility records in both countries show that women and children (especially girls) were the majority of cases serviced at the centres.[549] In South Africa, these were mostly poor Black and Coloured women and girls. In Kenya these were mostly women living in low-income settlements and rural areas.

5.4. Key Features of Kenya's GBVRC Integration Models in Kenya

5.4.1. Practice-emergent Models with no Formal Policy or National Strategy

Sexual violence service integration models in Kenya are not governed under any national policy; the integration centres operate independently, without any formal national strategy that establishes or unifies them collectively. This was evident from interviews with service providers which showed that the centres were established in diverse ways, with varying focus

[547] Interview with forensic doctor at SA.A.1 1st November 2016.
[548] See below Chapter 5 Section 5.5.1
[549] See below Chapter 7, Section 7.4.1 b)

areas that each centre determined for itself. For example, one key informant speaking about Kitale District Hospital Gender Recovery Centre (GRC) said, 'for us, for our project…our focus is mainly sexual violence against youth, our project's main aim was to create a case management system, where the stakeholders communicate.'[550] This participant used the phrases 'for us' and 'our project' continuously in the interview to differentiate the Kitale GRC from other integration centres in the country. This centre was established through a partnership with Handicap International, an NGO based in Kitale District, and the Ministry of Health.[551]

In another centre, Nairobi Women's Gender Violence Recovery Centre (GVRC), one participant described the focus area of the centre in this way: 'We do everything here on gender based violence especially domestic violence, intimate violence, that is husband to wife, parents to child, and also sexual abuse among both children and adults.'[552] It is clear that this broad aim differs from the narrow focus of Kitale GRC, as explained above. The Nairobi Women's GVRC was formed as a 'private charitable organization of the Nairobi Women's Hospital'[553] and is described as a 'model referral centre of excellence that provides free medical treatment and psychosocial support to survivors of gender based violence.'[554] Another participant at the Nairobi Women's GVRC also explained that the centre integrates their legal aid services through a 'memorandum of understanding with two NGOs one for children and the other for adults'.[555] These MOUs were negotiated independently between this private hospital and the legal aid NGOs, and this partnership was formed independent of any state policy or strategy.[556]

The other two of the four integration centres in Kenya were established 'courtesy of LVCT Health'[557], a health systems national NGO with a focus of HIV prevention care and treatment,

[550] Interview with a program manager, Handicap International at Kitale GRC on 6th February 2016.
[551] Ibid.
[552] Interview with counselling psychologist at Nairobi Women's GVRC on 31st January 2017.
[553] Interview with program manager at Nairobi Women's GVRC on 2nd February 2017.
[554] Nairobi women's GVRC website accessed at http://gvrc.or.ke/on 18th May 2018.

[555] Interview with program manager at Nairobi Women's GVRC on 2nd February 2017.
[556] Ibid.
[557] Interview with nurse at Nakuru PGH GBVRC on 21st January 2015; Interview with social worker at Kenyatta GBVRC on 8th June 2016.

in partnership with the Ministry of Health.[558] These centres are Kenyatta National Hospital GBVRC and Nakuru Provincial Hospital GBVRC. These two centres share the same name 'GBVRC', which varies slightly from the names of the other centres, as is explained below. These two centres also seemed to have similar general aims. For instance, the nurse in charge of the GBVRC at Nakuru Provincial General Hospital described the overall aim of the centre as 'what we are doing really is dealing with gender-based violence. We are giving integrated services, we are sending survivors to the other areas to get other services they need'.[559] She went on to explain that these other services that are integrated through external referrals include legal aid offered through partnership with NGOs and paralegals, as well as shelter services.[560]

Therefore, integration centres in Kenya are established independently in different parts of the country, arising from the efforts of different partnerships of donors, NGOs, private institutions and state agencies. Although the centres were established under different circumstances, they have a common underlying theme of facilitating comprehensive, integrated gender-based violence services.

It is important to note that these four integration centres have different names. While I use the term 'GBVRC' in this study for ease of reference, two centres use slight variations of this name. The centre at Nairobi Women's Hospital drops the 'B' for 'based' in the name and is known simply as Gender Violence Recovery Centre (GVRC), while the centre in Kitale District Hospital has no 'based' or 'violence' and is known as Gender Recovery Centre (GRC). This variation in names yet again follows from the different, independent, practice contexts and stakeholder partnerships from which the centres emerged. However, the common elements of 'gender', 'violence' and 'recovery' shows how congruence in interventions can emerge from practice, despite the absence of a specific national strategy, policy or blue-print for establishing or scaling up such integration models.[561]

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[558] LVCT programmatic focus is on HIV Testing, HIV Prevention, Care and Treatment and Sexual and gender Based Violence as articulated in their Strategic plan, accessed at http://lvcthealth.org/about-us/ on 15th May 2018.
[559] Interview with nurse KE.C.1 on 21stJanuary 2015.
[560] Ibid.
[561] Other GBVRCs which did not form part of this study also have similar names, see the GBVRC at Coast Provincial General Hospital accessed at http://icrh.org/news/gender-based-violence-recovery-centre-gbvrc-mombasa-

5.4.2. Congruence in GBVRC Implementation Approaches, Despite Independent Emerging Patterns

The similarities among these integration centres in Kenya show that despite the independent, sporadic way in which they emerged from practice, a common approach to service integration can be discerned. For instance, the centres are all based in health facilities and operate a similar service integration model where health and psychosocial services are mostly offered on-site, with legal and justice services being integrated through external referrals to NGOs and the gender desks at police stations.

Also similar is that in all the centres, NGOs take significant and similar responsibilities for provision of services, especially legal aid, counselling, social work and shelter services. For example, in Kenyatta GBVRC[562] and Nairobi Women's GVRC,[563] both in urban settings, the same NGOs were providing legal aid services to both child and adult victims of sexual violence. NGOs also provide safe house and shelter services linked to these two integration centres.[564] In the other two centres, NGOs also trained community paralegals and pro-bono lawyers who were provided legal aid services to victims at these centres.[565]

Table 2 above also shows that each of the fours centres also had one key donor funding their multi-sector collaboration activities, such as multi-disciplinary training, team meetings, community engagement, and other capacity-building activities. Kitale District GRC, Handicap International, an NGO took significant responsibility through financing the establishment of the centre. Kenyatta GBVRC and Nakuru GBVRC, identified LVCT as the key funder for collaboration activities, while Nairobi Women's GVRC was largely funded by Nairobi Women's Hospital since it is a charitable trust of this facility. Therefore, the government does not fund any service integration activities, other than providing the structural base in which the centres

kenya-received-label-unesco-chair-sexual on 18th May 2018; See also GBVRC at Jaramogi Oginga Odinga Teaching and Referral Hospital (JOOTRH) accessed at http://www.awcfs.org/index.php/content-development/features/item/1151-gbv-centre-established-in-kisumu on 18th May 2018.

[562] Interview with legal aid officer KE.B.2 on 8th June 2016.

[563] Interview with legal aid officer KE.A.5 on 31st January 2017.

[564] Interview with shelter/safe house manger KE.B.3 on 9th June 2016.

[565] Interview with paralegal KE.C. on 18th January 2016

are based, for those in public hospitals, and health services provided by those employed in the hospitals.

Some participants explained that the challenge of depending on NGO funding is that it was not sustainable. When the projects ended, service integration was compromised. For example, one social worker who was no longer able to provide services formally because the NGO project that facilitated her service came to an end, said:

> The county government, health department should be responsible for collaboration because it may be neutral. It could be an NGO but those organizations that come and go, I don't know where they will get the funding from.[566]

This social worker explained that NGOs as funders of service integration were not 'neutral' because their priority areas shift easily based on funding. She also explained that these NGOs are unable to train all relevant stakeholders, meaning that only a few stakeholders get the opportunities for capacity building. [567]

Also similar is that the centres in Kenya generally have weak linkages between health facilities and the legal and justice systems, including the police and courts. One key informant said, 'we have noticed that there are around 400 cases reported at the hospital and at the police there are 100 cases, and at the courts they are even much less that.'[568] A social worker expressed the same challenges in this way: 'the demoralizing part (of service integration) is when it comes to the legal services, but within the health facility it is good.'[569] During discussions with victims of sexual violence who were supported through the same integration centre where this social worker is based, one participant stated that 'the place where things are not working is at the police and the courts.'[570]

[566] Interview with social worker KE.D.1 on 3rd February 2016.
[567] Ibid.
[568] Interview with key informant KE.D.5 on 2nd February 2016.
[569] Interview with social worker KE.C.2 on 20th January 2016.
[570] Group interview with care givers of child victims of sexual violence at centre KE.C on 17th January 2016.

This weak linkage between the health services and the police compromised collection of forensic evidence and the chain of custody. For instance, when asked to describe the collaboration between the health and legal sectors, one key informant, responded 'Terrible!',[571] and then told a story about 'this lady who was given a run around back and forth after her child was sexually assaulted'.[572] This participant went on to explain that in that case, the police and health workers 'basically sent her up and down through-out the whole week and the evidence which was still on her had been washed away'.[573]

One main reason for the weak linkage between the GBVRCs and the police is that there are no linkages on a structural level across the sectors. At face value the police gender desks seemed to be the point of contact for specialised police response and investigation. However, participants explained that the referral mechanisms between the centres and the police were rather vague or general and not systematized. One health worker explained her challenge when referring cases to the police in this way:

> We have many police stations and getting one person in charge to work with is difficult… you can get lost dealing with so many people (investigative officers), so it gets difficult, but we are trying.[574]

These similarities among the centres point to a common approach to sexual violence service integration, which can arguably be traced to ongoing shifts in national policy development processes[575] and donor funding patterns.[576] For example, the national guidelines on management of sexual violence in Kenya emphasizes the need for comprehensive responses to sexual violence.[577] Some participants mentioned this national guidelines as a document

[571] Interview with key informant KE.A.4 on 3rd February 2017.
[572] Ibid.
[573] Ibid.
[574] Interview with SANE nurse KE.C.1 on 21st January 2016.
[575] Kenya Sexual Violence National Guidelines, above note 4. In addition, the policy development processes have been marked by national discussions under the mandate of the Taskforce on the Implementation of the Sexual Offences Act (TFSOA), which included most of the stakeholders who established and facilitated these integration centres in the country. See the TFSOA, *Report of Stakeholders workshop in the field of Gender Based Violence (GBV) launched 2nd April 2012*, 2011.
[576] Gruskin, S., Waller, E., Safreed-Harmon, K. et al., above note 31. This study shows how donor funding patters, particularly open society foundations (OSF) have shaped integration of health legal services to address sexual violence in Kenya and other low and middle-income countries.
[577] Kenya Sexual Violence National Guidelines, above note 4.

that framed their practice, for example in terms of clarifying the different stakeholder roles,[578] or types of evidence that can be useful in prosecuting rape cases.[579] It is important to note that this framework largely addresses comprehensive service integration within health care, with components of psychosocial support, but does not provide an overall framework for integrating legal and justice sector actors beyond forensic management.[580]

5.4.3. Support Groups are a Central Part of Kenya's Integration Models

With slight variations in operation, all the four integration centres in Kenya operated victim support groups, which offered the option of group counselling and support for sexual violence victims, in addition to the one-on-one counselling sessions. These groups were convened at the centres and facilitated by the counsellors or social workers. Support groups formed part of how the integration models provided psycho-social support services. The centres operated a similar model where participants met once a month for approximately one year, depending on the needs of victims and their willingness to participate.[581] In one GBVRC, the nurse coordinating the centre explained that support groups were established so as to ensure there was follow up for victims, and it facilitated tracking case progress. She explained:

> We really wanted to know what happens to them after we treat them, we didn't have anyone telling us what happens and that is why we came up with the support group. With our facilitation from here, we are able to know how they are going on, what is happening and where they are stuck.[582]

A common approach across all the centres was to run different support groups for separate categories of victims, based on the form of violence experienced. For example, a counselling psychologist at one GBVRC explained that they have 'different support groups for different cases including child groups, care-giver groups, domestic violence support group, and one for adult victims of sexual violence.'[583] These different categories of support groups ensure that

[578] Interview with key informant KE.D.5 on 2nd February 2016.
[579] Interview with key informant KE.A.4 on 3rd February 2017.
[580] Kenya Sexual Violence National Guidelines, above note 4.
[581] Interview with counselling psychologist KE.A.1 on 31st January 2017.
[582] Interview with SANE nurse KE.B.4 on 8th June 2016.
[583] Interview with counselling psychologist KE.A.1 on 31st January 2017

'people who have gone through the similar issues can share information and help each other.'[584] The other three GBVRCs similarly utilised this approach.

In some centres monthly support group meetings also served as information sessions, training sessions and debriefing sessions, where the 'victims shared information and helped each other'[585] by discussing challenges they experienced. In this way support groups were an important part of voicing the needs of victims and finding ways to collectively find solutions to some of them.

Support groups are also a way to link victims to community-based resources such as economic empowerment programs to assist in providing long-term support to break the cycle of abuse. One counsellor explained that:

> Once they are finished doing the support group, doing the process we also empower them economically whereby if someone is being abused but we cannot break the cycle of violence because this person depends on their spouse for a living we give economic empowerment training, it's a way for them to break the cycle of abuse.[586]

Since the support groups largely depend on NGO funding to operate, their continuity is interrupted by inconsistent funding or when NGO projects end. For instance, in one centre, the support group had recently re-located and was now being hosted by a local community-based organisation (CBO).[587] This change happened after an NGO project, which was funding transport costs for the support group meetings at the centre, ended.[588] I met with sexual violence victims supported through this centre at the offices of this CBO.

During the discussions, some victims explained that one benefit of being in the support group is that it provided a community of people to share similar experiences which assisted with healing. One participant explained in these words:

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[584] Ibid.
[585] Interview with counselling psychologist KE.A.1 on 31st January 2017.
[586] Interview with counsellor KE.A.3 on 3rd February 2017.
[587] Fieldwork notes from research visit to KE. D on 5th February 2016.
[588] Ibid.

> We joined the support group at the centre together and I realised that I could explain myself and the heaviness could lift off of me, it is like this woman has said here (she gestures in agreement to a participant who had spoken earlier) … 'the one who has not gone through it will think it's a joke, but the one who has sat on the fire and has been burnt will know it is a wound.[589]

Another participant similarly said: 'When I had the sadness, I came here (to the support group hosted by the CBO) and I was encouraged and trained about gender-based violence, and I felt I am ok.'[590]

From these accounts we see that support groups are useful as a follow-up strategy. It also makes it possible to identify victims' needs, so as to assist them. In this way support groups were instrumental in providing support structures and care for victims, enabling them to heal and move on. In addition, this component of the centres was a way to sustain long-term contact with victims to identify their shifting needs. Using the resources of the collaboration networks, the centres would then try to meet the multiple needs of victims. This intervention also empowered victims through linking them with community-based resources to break the cycle of violence. These are all elements of the state's obligation to protect women and prevent reoccurrence of violence, that is, secondary prevention. In this way Kenya's integration approach creates a service response that effectively supports victims beyond the moment of crisis, or emergency, to dealing with the medium- and long-term consequences of sexual violence.

5.4.4. Integration Approaches in Kenya are Referral Networks not 'One Stop Centres'

Kenya's integration models are not 'one stop centres' (OSC) in the sense that all services are available under one roof, or linked through systematized institutional referrals. Rather, the integration approach in Kenya operates as referral networks which can be loose or dense depending on the nature of both formal or informal partnerships and relationships among the players. This was evident both from express statements made by different service

[589] Group interview with sexual violence victims at centre KE. D on 5th February 2016.
[590] Ibid.

providers as well as inferences I drew from how the different services were being coordinated, as explained in sections above. For example, one program manager stated:

> The GBVRC is not a one stop shop. That is why we look for external organizations to come and complement and pick up from where we are able to carry our mandate. For example, we treat (medical treatment), offer counselling, we send our doctors to go represent our survivors in court, but now we don't have lawyers and clerks, that is why we have a memorandum of understanding with two organisations directly working with us to provide legal aid.[591]

Similarly, a trauma counsellor at a different centre, explained:

> I think we have tried as a health sector, but there are also gaps because this is not a one stop centre where the police are there, the children's department are there, the social worker is there, and drugs are just there, and even a recovery room…but if it was a one stop centre where everything is done under one roof, it would be better.[592]

Likewise, another participant also explained:

> 'If you are raped, you need to be treated, get counselling and also legal aid in one place, but this is not the case in Kenya, where you come to the GBVRC and then you go to Kilimani police station which is like 5 Kilometres away and then you go to hospital which is like 3 Kilometres away. And that is in Nairobi. But if it is another town we are talking about 30 Kilometres away from each other. So ideally, we should have one stop centre, which we are going to leave that for the government.[593]

These perspectives describing the GBVRCs as referral networks, rather than OSC models differ to some extent to the perspectives of an earlier empirical study on multi-sector responses to sexual violence in Kenya. [594] This earlier study found that there are three types of OSC in Kenya:

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[591] Interview with program manager KE.A.2 on 2nd February 2017.
[592] Interview with trauma counsellor KE.D.2 on 3rd February 2016.
[593] Interview with case manager KE.A.6 on 2nd February 2017.
[594] Keesbury, J., Onyango-Ouma, W., Undie, C. et al., above note 56.

> The first model the health facility-based OSC, —'owned' by a hospital, the second health facility-based OSC, —'owned' by an NGO, and the third type is the stand-alone, 'NGO—owned' OSC which provides primarily legal and psychosocial support onsite, while survivors are referred elsewhere for health services.[595]

That study defines OSC more broadly to include the GBVRCs that I assess in this dissertation as well as the NGOs that may offer one or two core services such as legal aid and counselling services, with external referrals for health services. [596] However, this thesis findings show that the GBVRCs are rather understood in practice as mains point of intersection for the networks of comprehensive sexual violence services, not OSC.[597] As exemplified above, most participants pointed out that they would like, in fact, to transition from referral networks to being OSC that provide all services under one roof. For example, one participant said that the solution to weak linkages between the police and health facilities would be 'a one stop centre. I don't see any another option, a real one, not the ones that we say they are and are not. A real one with trained personnel'.[598]

Therefore, I use the broader term 'integration centres' with an understanding of the service integration context being more of a fluid referral network, rather than different types of OSC. I see these referral networks as providing differing degrees of comprehensive sexual violence services, with the GBVRCs being the main point of intersection for the services. Terminologies used to describe service integration models are important in mapping how many comprehensive care centres are available in the country. The empirical study by the Population Council, by its definition of OSC, estimated that there are approximately 20 such comprehensive care centres in Kenya. However, based on how participants in this study describe service integration, my estimation is that there are approximately seven such integration centres in the country, four of which I studied.[599]

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[595] Ibid at 11.
[596] Ibid.
[597] Interview with legal officer KE.A.5 on 31st January 2017.
[598] Interview with key informant KE.A.4 on 3rd February 2017.
[599] The other three integration centres in the country that are not included in this study, which fit the description of integration that I use are; Mombasa Coast Provincial General Hospital GBVRC, JOOTRH GBVRC, Kisumu and CARE GBVRC, Moi Teaching and Referral Hospital (MTRH).

5.5. Key Features of South Africa's TCC Integration Model

5.5.1. TCCs are a Systematized State-led Integration Approach

The TCCs emerged in 1999 as the key South African government nation-wide response to sexual violence. [600] At the time of this study 55 TCCs have been established across the country.[601] The three-fold mandate of the TCCs are; reducing secondary victimisation in the processing of sexual violence cases, increasing conviction rates, reducing the turn-around time for finalization of cases.[602] While the National Prosecuting Authority (NPA) is the lead agency, participants explained that the TCC model depended on the partnership of all other relevant sectors to function, as one key informant noted:

> The NPA is the driving force, and yes, we conceptualized the model, but we wouldn't have been able to do it without good partnership… we cannot do so in isolation… so for me what makes the model work is good stakeholder cooperation.[603]

The NPA provides three key personnel based at the TCCs, including the case manager, victim assistant officer and site coordinator, who together facilitate case management and follow up by tracking the progression of the case through the criminal justice system.[604] As a multi-sector model, the NPA is involved in partnership with other state agencies, including the Department of Health (DoH), the South African Police Service (SAPS), the Department of Justice (DoJ) and the Department of Social Development (DSD).

A unique feature of the TCCs is their intentional location in primary health care facilities. As one doctor explained: 'each centre must be attached to its hospital, specifically on a district level because you have different levels of primary care…to make the service closer to communities'.[605] This is different from integration approaches in other contexts commonly

[600] Artz, L., Smythe, D. & Leggett, T., above note 50.
[601] Jordaan, S., Slaven, F., Louwrens, C. et al., above note 49.
[602] South Africa NPA TCC blue print, above note 43; Vetten, L.., above note 53.
[603] Interview with key informant SA.KI.1 on 16th May 2017.
[604] Interview with key informant SA.KI.2 on 16th November 2016.
[605] Interview with forensic doctor at SA.A.1 1st November 2016.

based in secondary and tertiary facilities, which are often appraised as more effective, due to their proximity to more specialised services.[606]

The DSD as a collaborating partner 'is contracted to provide counselling'[607] through 'funding service organisations based in communities or structures within communities.'[608] Through this financial support from DSD, NGOs like Rape Crisis[609] and Mosaic[610] are able to provide crisis counselling services to the TCCs through volunteers.[611]

The SAPS is involved in the TCC model through the Family Violence, Child Protection and Sexual Offences Investigations Unit (FCS Unit). The FCS units provide specialized police response to matters of gender-based violence, child protection and family issues.[612] These investigating officers operate by regional clusters, which include a number of police stations marked by jurisdiction. Through this unit, the police have formed a partnership of systematic referrals between multi-disciplinary teams of health, legal and social workers working at each of the TCCs. In their reception areas, all the four centres had pinned on their walls, a list of the specific investigating officers from the FCS unit serving their jurisdiction, with their contact details, who were available on call.[613]

Service providers described the referrals between the TCCs and the police as effective because of these pre-established, institutional linkages with specific stations in their regions. One site coordinator explained that referral was effective because the police came to the centres promptly when called. She said, 'I must say, partnership is a very important component…it is just easy, you pick up the phone and call and they are here right away'.[614] One FCS officer explained that their response is prompt because for one TCC the officers in the unit, 'work in four groups, three members per group on standby. So, whenever your group

[606] Colombini, M., Mayhew, S. & Watts C., above note 63.
[607] Interview with key informant SA.KI.1 on 16th May 2017.
[608] Interview with key informant SA.KI.3 on 6th June 2017.
[609] Rape Crisis provided counsellors at two of the four TCCs; Karl Bremer and Heideveld.
[610] Mosaic provided counselling at the other two centres; Worcester and Atlantis TCCs.
[611] Interview with key informant SA.KI.3 on 6th June 2017.
[612] Frank, C. & Waterhouse, S. 'One step forward, two steps back? The impact of the SAPS restructuring of the FCS Units.' (2009) 28 *SA Crime Quarterly* 25.
[613] Fieldwork notes from observation data collected in all four TCCs between October 2016 and March 2017.
[614] Interview with site coordinator SA.C.1 on 13th March 2017.

is on call then you will be responsible for all the stations on the N1 highway. So, any complaint during that period I must attend to.'[615] This collaboration system between the TCCs and FCS police officers is set up in anticipation of cases being reported, with clarity around who is responsible for responding at any given time. The strong link between the health facilities and the police facilitates effective completion of medico-legal documentation and maintaining the chain of evidence. One doctor explained that the system of police officers coming to the centre ensures the chain of evidence is not broken because,

> The medical officer's hand over the (forensic) kit to the police officers, they have to sign, and we also have to know where to take the kit to. I mean when they (police) come in here (TCC), I introduce myself, it if is a new detective that I do not know. The network around is very good.[616]

The DoJ is also involved as a partner with regards to processing of TCC cases through the courts, especially the specialised or dedicated sexual offences courts.[617] According to the TCC blueprint, the centres are supposed to be linked directly to sexual offences courts. However, with the demise of the sexual offences courts in South Africa, these dedicated sexual offences courts emerged, operating as hybrids by giving priority to sexual offences cases, but taking on other matters when no or no further sexual offences cases are on the court roll.[618] Of the four TCCs I studied, two, Wesfleur and Karl Bremer, were linked to such hybrid courts, in Atlantis and Parow, respectively. One centre, Heideveld (formerly GF Jooste) is linked to the Wynberg sexual offences court, which is fully fledged. While the fourth centre, Worcester, is not directly linked to any dedicated or specialised sexual offences court, rather they work with a prosecutor that is focused on prosecuting sexual offences in the court.[619] There are ongoing reform processes that one participant described as a 'resuscitation of the sexual offences courts to upgrade the present hybrid courts to the NPA sexual offences court's blue print.'[620] A key feature defining multi-sector collaboration for the TCC are protocols, which are documents developed through consensus that define the roles of each actor in the network.

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[615] Interview with police officer SA.C.2 on 15th March 2017.
[616] Interview with medical officer SA.C. D on 16th March 2017.
[617] MATTSO Report, above note 475.
[618] Ibid.
[619] Interview with prosecutor SA.D.5 on 18th November 2016
[620] Interview with key informant SA.KI.1 on 16th May 2017.

A key informant explained that the 'the most difficult part in managing multi-disciplinary teams is getting them to commit to what they have to do.'[621] He then explained that the TCC protocols were instrumental in shaping and clarifying stakeholder roles and commitments. One service provider similarly explained the centrality of the protocols to effective integration in this way:

> We have the Thuthuzela protocols, there is a general model and of course there is also a piece for our specific centre … we sit around every year and fight about amending it just to make sure every year it's relevant to us.[622]

He went on to say that there are also standard operating procedures (SOPs) and other principle documents which have been 'implanted for each centre to make sure they are very much relevant to the people who are working on the ground.'[623] The centrality of TCC protocols and SOPs in facilitating integration was an opinion carried by many other participants across the four TCCs. This section has shown that as a key feature, the TCCs operate a multi-sector collaboration system that is institutionalised through state departments, before being cascaded down to the service providers' level at each centre.

5.5.2. TCC's are Emergency/Crisis Centres - 'One-Stop' Only at First Point of Contact

Several participants described the TCCs as OSCs that provide all relevant services under one roof to address the challenge of victims moving from 'pillar to post'[624] when seeking recourse. This quote by one police officer captures the common sentiment on why the model was considered as a successful practice. He said, 'everything is centralised, everybody comes to one point then you get all the help you can need under one roof. The police is here, the doctor is here, the nurses are here, and everything is here'[625]

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[621] Interview with key informant SA.KI.2 on 16th November 2016.
[622] Interview with forensic doctor SA.A.1 on 1st November 2016.
[623] Ibid.
[624] Several participants referred to the 'pillar to post' idiom as the motivation for the establishment of the TCCs. It generally refers to the inconvenience that a victim of rape would have to travel from one service to the next in pursuit of justice.
[625] Interview with police officer SA.C.2 on 15th March 2017.

However, although the OSC model means that all emergency services can be provided at one place, when needed, not that all the service providers are located in one centre. As described above, the FCS police officers are not based at the centres, they are available on call through established systematic linkages between the sectors.[626] Similarly, case managers are not based at the centres, they are based in court, but through the site coordinator, victim consultations with them can be arranged systematically. [627] These case managers follow up the case through the criminal justice system and transmit case information through the centres' site coordinator to the victim assistant officers who in turn transmits information to the victim.

Therefore, the OSC ideal is not literal, it is an assurance that through systematic linkages among sectors involved the relevant service providers will come to the TCCs to provide services when called upon. It is this systemic linking of institutions, roles, structures and key personnel based on-site that characterises the TCCs integration approach. From my observation and interviews with stakeholders involved, services were provided on a 'one stop' basis only at the victim's first visit or first point of contact with the centre. The TCC model offers an emergency package of care, which was often described by participants as involving recently reported cases that have just been reported to the police. The quote below exemplifies the typical flow and trajectory of TCCs emergency rape response:

> A victim reports the matter to police. The police take her to the TCC, where she receives immediate trauma containment to calm her down. Then a file is opened and her information entered in the database which means now we are tracking her. The victim assistant officer will inform the doctor that the victim is ready for medical examination and the doctor will come. So, all these services must be provided within 2 hours. The doctor does the medical examination and completes the rape kit. There is communication with the investigation officer to say the victim is done and they can come to collect her. While she waits, she takes a bath and a shower. When we have clothing we can provide her with those and a comfort pack. The investigating officer

[626] Ibid.
[627] Interview with case manager SA.B.4 on 24th March 2017.

> will then take her home if it is safe for her and then the victim assistant officer will keep in contact with her.[628]

Therefore, the TCC model's key services are structured to respond to sexual violence cases at the moment of crisis, with the central focus of calming a traumatised victim, and collecting forensic evidence for purposes of police investigation and prosecution. This emergency response was also clear from the counsellors' descriptions of their services as containment counselling with the central purpose of preparing or inform the victim of the medical examination procedures to follow. For instance, one counsellor explained:

> When a victim comes, I counsel her about the rape, and I contain her in the crisis containment room. Containment counselling just means that if the patient cries, you allow her to cry so that by the time she reaches the doctor she could be in a calmer position so that the doctor could do his work.[629]

The TCCs do not provide other psychosocial support services besides containment, and victims are referred to external NGOs for continued counselling and other long-term victim support. However, the linkages and referral systems between the centres and these external service points were weak or unclear because referrals were made generally without a clear plan of follow up. A similar finding emerges from the most recent audit evaluating TCCs nationally, which finds that there are concerns among service providers that the TCC design does not cater for victim's long-term psychosocial needs.[630] All the four centres highlighted that referrals for continued counselling was a challenge due to limited capacity to follow up. One participant said, 'if it is maybe one or two victims it is ok to maintain connection, but as you have heard, we have had over 30 cases last month, it is difficult'.[631]

These findings show that, by design the TCC is a crisis or emergency rape response model which is set up to provide care particularly for pre-72-hour victims, reporting to the police. This component of the TCC contributes to the fulfilment of the state's obligation to protect,

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[628] Interview with key informant SA.KI.2 on 16th November 2016.
[629] Interview with counsellor SA.A.6 on 23rd November 2016.
[630] Jordaan, S., Slaven, F., Louwrens, C. et al., above note 49.
[631] Interview with key informant SA.KI.2 on 16th November 2016.

because the victim who reports does not have to move from one service point to another in a fragmented system where critical forensic evidence can get lost. In addition, co-ordinated emergency response has the potential to facilitate secondary prevention because it avails an opportunity to ensure the victim is referred to a safe place, or the perpetrator is arrested, detained or otherwise removed from the victim's environment to avoid further victimisation.

However, the lack of strong referral systems, or follow up strategies beyond the moment of emergency means that the model has no effective way of sustaining contact with victims, unless their cases are being investigated or prosecuted.[632] This lack of sustained contact with victims whose cases are not being prosecuted makes it unlikely for the integration centres to identify and respond to other victim needs, such as comprehensive health and psychosocial support. This gap is a significant challenge because lack of follow up or sustained contact means there is no avenue for the victim's voice in the system of response.

The absence of sustained contact with victims, the lack of avenues to identify and respond to the emerging mid- to long-term needs of sexual violence victims compromises the fulfilment of state obligations to prevent and effectively respond to sexual violence. This lack of long-term contact beyond emergency response compromises the same state obligations to protect and prevent reoccurrence, because it limits avenues for knowing or responding to a situation where the victim safety is compromised after reporting, or more importantly, because of reporting. In addition, by primarily providing continued counselling and maintaining contact with victims whose cases are being investigated or prosecuted, the TCC model compromises the state obligation to provide redress to victims beyond the criminal justice system.

5.5.3. Unequal Sector Involvement in the TCC's

Several participants explained that the TCC model's success was pegged on a multi-sector collaboration approach where sectors are leading together, being involved equally or taking

[632] This exception as explained earlier, is because the role of the case manager and VAO is to track the cases that are progressing though the criminal justice system. Therefore, the TCC model has an effective way of tracking the progress of cases that have made it to court.

equal responsibility in the collaboration. For example, one health worker explained that the TCCs model's success was dependant on:

> collaborative leadership… so this hierarchical medical thing of top-down management ruling by decree is not the way forward…It's a flat-style of management where almost anyone has a leadership function and people collaborate with each other without having a stick to be beaten into shape…it was stunning because medical school doesn't teach us this. It is very much about ruling by decree and so when I experienced it seen that it works; I couldn't see any other way to do it.[633]

This health worker describes how the collaborative culture of the TCC model challenged the hierarchical ways of operation within health systems structures, to which he was accustomed. However, some interviews revealed that equal involvement of sectors was an ideal that was not always realised, mainly due to competing and sometimes conflicting sector mandates. For example, the DSD was often described as unwilling to collaborate effectively, while contrasting opinion from DSD showed that they were never equally involved in the integration model. For example, one site coordinator said, 'so, we have invited DSD, they come and go, we have a challenge with them they don't really come on board.'[634]

On the other hand, a key informant from the DSD explained that by design, the TCC model was an NPA project that focused primarily on partnership with DoH, DoJ and NPA, with the DSD not being equally involved as an equal partner from the beginning. She noted:

> Remember the NPA is a custodian of the TCC it's their blue print so the NPA runs with it…also if you look at the blue print, their model is health, because all TCCs are linked to a health centre so I think strategically… it makes sense that that is a key partnership (DoH and NPA) and there is nowhere an agreement that says DSD must come to the table, you understand. Whereas with NPA and DoH they must work together to be called the TCC, we were never part of that initial negotiation.[635]

[633] Interview with forensic doctor SA.A.1 on 1st November 2016.
[634] Interview with site coordinator SA.B.6 on 27th March 2017.
[635] Interview with key informant SA.KI.3 on 6th June 2017.

One participant explained further that perhaps the DSD's lack of consistent presence and involvement in the TCCs is because they consider their role sufficiently discharged through supporting NGOs like Rape Crisis to provide containment counselling. She said:

> In terms of providing a service I don't want to complain they (DSD) are there…but they don't want to show commitment where they would involve themselves here. But they provide funding, specifically a percentage to rape crisis to provide a service (containment counselling) here. So, it could be that they say: "look we are covered because we are paying an NGO to be there on site." [636]

This unequal involvement between the sectors is a challenge that has been described by one study as the TCC model's greatest weakness because, since not all sectors are equally involved, there is no way to ensure accountability.[637] As a result of this unequal involvement some of the DSD services, such as shelter services, were not being sufficiently integrated into the TCCs. As one DSD key informant noted:

> The Thuthuzela is just part of their (DSD shelters) general referral network, it is not that they are directly linked. I must say, I look at the numbers, and the TCCs is definitely not in our top five referral sources.

Therefore, there is disconnect between the TCCs and the psychosocial service programs that the DSD operates. The DSD social work and shelter services provided through their victim empowerment program are operating parallel to the TCC interventions. This disconnect of partnerships between NPA and DoH on one side, and DSD on another compromises victims' access to holistic integrated services due to unequal sector involvement.

5.6. Comparing Services in Different Geographical and Resource Contexts

In both countries, well-resourced centres in urban areas had more robust multi-disciplinary teams who together worked to strengthen referral systems across the health, legal and social

[636] Ibid.
[637] Jordaan, S., Slaven, F., Louwrens, C. et al., above note 49.

service sectors.[638] However, centres in peri-urban and rural settings lacked one or more of these service providers, which meant the available personnel had to take on more responsibilities, compromising the quality of services and strength of the referral processes.

5.6.1. Health Services

In both countries, centres in urban settings are better resourced and have specialised, designated personnel providing health services, on site. For instance, all the four centres in urban areas (two GBVRCs and two TCCs) have designated specialised forensic medical examiners on-site.[639] In addition, the centres at tertiary level benefited from specialist services within the hospital, making referral for these additional services easy, as one forensic nurse in a GBVRC at tertiary level said:

> We have personnel that are highly trained in this hospital and where there are gaps we do a lot of consultations with them. So, they are well trained and apply their skills while offering services.[640]

Conversely, in both countries, centres in secondary and district-level facilities which are located in peri-urban and rural settings, depended on sharing health workers who also work in other hospital departments. These health workers were not always available to offer services at the centres, and this caused delays in treatment, forensic examination and filling in medico-legal forms. In one GBVRC, a nurse explained:

> We have a challenge because we only have two people who fill P3 form, and the same clinical officer is the one who is seeing paediatrics at the Maternal Child and Health Centre. So, when the clients come, they must wait for some time for him to finish and then he come this side to fill the forms. It is complicated, so if clients come you may tell them to go and come back the next day.[641]

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[638] For example, in Kenya, the better resourced urban centres have in-house social workers, trauma counsellors, counselling psychologist and established links to specific legal officers through NGOs who were constantly available to provide legal aid services. Similarly, in South Africa, well-resourced TCCs have all the requisite personnel for the model, that is, case manager, site coordinator, victim assistant officers, part time counsellors available for 24 hours, which facilitated better multi-sector collaboration and follow up of cases.

[639] Two GBVRCs have SANE forensic nurses while the two TCCs have Forensic medical doctors.

[640] Interview with SANE nurse KE.B.4 on 8th June 2016.

[641] Interview with nurse KE.D.3 on 3rd February 2016.

Similarly, due to lack of training and having only one designated health worker to fill in the medico-legal forms, reporting and investigation processes are delayed. One social worker explained:

> Sometimes the P3 form is not yet filled, the main doctor is difficult to find because maybe it could be his court date, or he is not around. The other doctors will refuse, they say, "I will not do that work, and if you want me to do it, you have to pay me extra."[642]

This participant went on to say that health workers refuse to fill in the medico-legal forms because 'they fear the legal processes, they say they don't want to chase around people in courts.'[643] Due to these challenges - lack of capacity, training and willingness by general health workers to provide services at the GBVRCs - victims are often forced to pay extra money to receive the service, or to wait until the health worker who is considered better trained becomes available.

TCCs in rural and peri-urban settings had similar challenges. In one of the rural TCCs, one participant said that one of the centres' needs is 'to have dedicated full time forensic nurse because sometimes there are medical emergencies… and the victim can be kept waiting for a doctor for more than two hours'. [644] The challenges of depending on shared, shift-based health workers from the main hospitals emerged as a common challenge across centres in rural and peri-urban centres.

Over time one of the TCCs had developed ways of overcoming these challenges through negotiations with the hospital administrative management to allocate specific health workers to the centres on a roster basis, so that there was always a health worker available.[645] However in case of medical emergencies, delays could not be avoided since the centres have no designated health workers.[646] Consequently, the lack of specific health workers based at

[642] Interview with social worker KE.D.1 on 3rd February 2017.
[643] Interview with social worker KE.D.1 on 3rd February 2017.
[644] Interview with case manager SA.C.3 on 15th March 2017.
[645] Interview with case manager SA.C.3 on 15th March 2017.
[646] Ibid.

the TCC centres caused delays with medical services, which led to delays in the filling in of medico-legal documentation, compromising the police investigation processes.

By linking victims to the provision of free medical services, provided by trained health workers, the integration models in both countries contribute to fulfil the state's obligation to protect by reducing chances of gender bias and secondary victimisation during the medical examination. However, the lack of training and capacity of health workers, especially in rural settings, affects medical treatment, examination and filling in medico-legal documentation. This causes delays, which affect women's access to health services and compromises effective investigation and prosecution of sexual violence cases.

5.6.2. Legal Services: Protecting the Process of Reporting, Investigation and Prosecution

Kenya's GBVRCs are linked to police officers at gender desks designated for gender-based violence reports. In addition, the GBVRCs integrate legal assistance through partnership with women's rights organisations that watch brief or monitor the prosecution of cases. Such arrangements provided the needed legal safeguard of a monitoring eye to the prosecution process where obvious miscarriages of justice could be avoided or confronted.[647] The TCCs use specially trained and designated case managers, who are often former prosecutors, to offer legal assistance in the criminal justice process.[648] The TCCs' link to specialised police units and specialised sexual offences courts integrates the legal and justice sector responses and keeps TCC case processing from mainstream service points.

However, the ideals of integrating specialised legal assistance to safeguard the processes of reporting, investigation and prosecution was compromised by variations in resource availability and location of the centres. For example, the well-resourced TCCs had all the three key TCC personnel necessary to facilitate linkages between the victims, hospital, police and court, that is, the case manager, the victim assistant officer and the site coordinator. However, the TCCs in peri-urban and rural settings did not have all three key personnel. As a result of these capacity gaps, increased work load compromised the quality of follow up and

[647] Interview with legal officer KE.A.7 on 27th January 2017.
[648] Interview with key informant SA.KI.4 on 12th April 2017.

referral systems. For example, the rural-based TCC did not have a case manager, which meant that the victim assistant officer had to be in court to support cases in addition to keeping victims informed of case progress and monitor referrals to other support services. [649]

Similarly, in Kenya, the GBVRCs in urban settings had well established partnerships with legal aid NGOs within their vicinity to support victims in court processes. However, the GBVRCs in peri-urban and rural settings did not have linkages to such NGOs due to the limited presence of such organisations in their geographical locations. For example, the rural-based GBVRC had previously integrated legal assistance services through a pro-bono lawyer's project by the only NGO providing such services in the district.[650] Once that project was closed, there was no other alternative structures that would provide legal assistance services to the centre.

5.6.3. Psychosocial Support Services

The integration of psychosocial support services also varied in availability and quality, based on the geographical and resource setting of the centres. Kenya's GBVRCs provided both individual counselling and group counselling through victim support groups, which, together, offered a way of sustaining contact to identify victims' psychosocial needs and to monitor their emotional progress. In well-resourced centres, these sessions were facilitated by specially trained, well experienced counsellors, social workers, or psychologists. In all the four centres, nurses were also trained as trauma counsellors and were therefore able to integrate medical services and counselling at the service-provider level. In Kenya, victim support groups in rural and peri-urban settings were compromised by lack of continued funding to support victim transport costs, given the long distances they travel to reach the centres.

In the same way as the GBVRCs, the specialised and otherwise dedicated ways in which the TCC centres sought to provide psychosocial support services were most actualised in well-resourced centres. TCCs provided crisis counsellors who had gone through basic training for gender-based violence first responders and trauma counsellors. In addition, victim's assistant officers, and site coordinator, together cater for and coordinate referrals to address

[649] Interview with victim assistant officer SA.D.4 17th November 2016.
[650] Interview with key informant KE.D.5 on 2nd Feb 2016.

psychosocial victim needs as the case is being prosecuted. TCCs in rural and peri-urban settings struggled with limited options of places to refer for continued counselling, shelters and other psychosocial support services.

5.7. Service Integration in Urban Centres: Well Resourced but Busy Centres

Although urban centres seemed better resourced in terms of having more providers and specialised personnel, they were not exempt from challenges of human resource and capacity gaps. Participants in these centres noted that they nonetheless struggled to meet the needs of victims because of their workload, given how busy the centres were. For example, in Kenya, the Nairobi Women's GVRC, supported a total of 3386 victims in the last 12 months alone.[651] This number is much higher in comparison to the centres in peri-urban and rural settings, which supported 601 and 467 cases, respectively, in the last 12 months.[652] One counsellor at the Nairobi women's GVRC explained that although they follow up some cases through victim support groups and make phone call check-ups 'there is however a backlog, and when the perpetrators get out on bond, the client sometimes does not understand.'[653] This participant was explaining a commonly-held perspective among participants that it is not possible to keep all victims informed about the progress of their cases.

Similarly, service providers in the urban-based, better resourced TCCs said follow up is difficult because 'the amount of survivors that we see a month, and to track back all the time, we are going to lose track of because there is only so much work that you can do'.[654] Therefore, despite some centres being better resourced, with infrastructure and specialised providers, human resource and capacity remained a challenge given their heavy workload.

5.8. Service Integration in Peri-Urban Settings: Limited Resources within Wide Jurisdictions

[651] Data from review of facility records, case flow statistics at Nairobi Women's GVRC. This data was for the period 2016-2017. It reflects the last 12 months at the time of my data collection.
[652] Review of facility records at Kitale District GRC and Nakuru PGH GBVRC between January and March 2016.
[653] Interview with psychologist KE.A.1 on 31st January 2017
[654] Interview with victim assistant officer SA.B.4 on 26th March 2017.

Centres in peri-urban settings raised peculiar challenges in collaboration and referrals because they serve wide regions, covering a number of districts, with diverse populations, both peri-urban and rural. Due to the wide jurisdictions of these regional, provincial centres, it was common practice that 'victims don't come back for their follow up appointments due to financial constraints and transport.'[655] Providers at these peri-urban centres knew that the only contact they sometimes had with the victim was that first visit. Unlike centres in urban settings, stakeholders within their referral networks such as NGOs and police stations are spread far apart across the province, as one participant in Kenya explained: 'We have so many police stations that we do not know how to deal with them'.[656]

To manage inter-sector collaboration in these wide jurisdictions, Worcester TCC invested in forming relationships with local clinics in the four districts falling within their jurisdiction. This helped in 'medical follow ups so that victims can at least continue with the medication'.[657] In addition, Worcester TCC strengthened their referral networks by having a specific, close knit, yet wide in scope, implementation meetings.[658] While the implementation meetings are a feature of TCCs generally, Worcester TCC participants noted that theirs has been quite successful because they got consistent representation from people in decision-making positions 'from all over the province, which has made it very stable over the years'.[659]

5.9. Service Integration in Rural Settings: Wasting Resources or Increasing Access to Effective Services?

The issue of establishing integration centres in rural settings raised questions of providing effective services on one hand and utility of the integrated service on the other. In both countries, the centres in rural areas had the lowest monthly average of cases received. Kenya's rural-based GBVRC had on average 51 sexual violence cases a month in the year

[655] Interview with site coordinator SA.C.1 on 13th March 2017.
[656] Interview with nurse KE.C.1 on 21st January 2016.
[657] Ibid.
[658] Interview with case manager SA.C.3 on 15th March 2017.
[659] Ibid.

2016/2016 and South Africa's rural-based TCC had an average of 18 cases per month for the same year.[660] In comparison to the urban comparators, Kenya's urban-based GBVRC had an average of 283 sexual violence cases per month and South Africa's urban-based TCC had an average of 130 cases for the same annual period 2015/2016.[661]

The question then is whether there is any use in investing resources towards establishing integration centres, if they are going to support very few cases. For example, one participant explained that the reason their TCC did not have a specialised forensic health worker is because they were not supporting as many cases as the busier centres in urban areas. One participant said 'the busy centres have got on site forensic nurses, all except for this centre. The reason being we are smaller, numbers are lower, so it is not programmable for them to have that position here.[662]

Part of the reason for the low numbers is that in rural settings, poor infrastructure, transport costs and logistics remain major hindrances to victims' access to the service centres, including victims' return for follow up visits.[663] Victims had to travel long distances to reach these integration centres, and additional distances to access services that are integrated through referral.

Despite the low numbers, some participants thought that establishing an interagency unit in a rural area should be seen as a way of bringing more effective integrated services to communities that lack such services. For example, the site coordinator at Wesfleur TCC explained that since establishment, the centre had filled a considerable service gap in that rural community. She said:

> We absolutely also know it is a need within our community, we have these types of crimes in our community and unfortunately, we had no place that sort of delivers that sort of service of this nature (integrated)… we want to make sure that people sort of regain their confidence in the justice system.[664]

[660] Review of facility records at Kenya's GBVRCs and South Africa TCCs between January 2016 and March 2017.
[661] Ibid.
[662] Interview with case manager SA.C.3 on 15th March 2017.
[663] Interview with lead counsellor SA.D.2 on 17th November 2016.
[664] Interview with site coordinator at Wesfleur TCC, Atlantis, November 2016.

This Wesfleur TCC, which had existed for slightly over a year at the time of data collection was described as an intervention that is addressing a pressing need for effective sexual violence services in a community plagued with poverty and gangster activity. Likewise, the Kitale GRC was seen as having provided the necessary dedicated and specialized services and referral links for sexual violence cases since it was set up.[665] These views show that while statistics may indicate a low uptake of services, the integration centres are valued as avenues that bring effective services closer to the rural communities, by harmonizing disjointed efforts. Therefore, deciding whether or not to have integration centres in rural settings, and to what extent they should be capacitated, should be based on constructions of utility that move beyond numbers as the signifier of value and uptake of services. These decisions should be based on whether the communities where the centres are hosted are being impacted positively by the presence of the centres, over time.

This section has shown that in both countries, human resource capacity and access to the integrated services vary by geographical and resource context of the centres. While at first glance urban centres may seem better resourced, their busy contexts mean that the available resources and capacities are spread too thin, leaving them resource constrained. Similarly, while peri-urban centres seem to be advantaged by their location in provincial health facilities, their location within wide jurisdictions means they have to exert extra effort to facilitate effective referrals in the entire provinces, which equally constrains their resources. Finally, the context of service integration in rural areas invites us to reconsider how the questions of utility are weighed against the value of availing such services in remote regions.

5.10. Barriers and Facilitators to the Collaboration Ideal

In both countries interviews revealed that effective service integration depended on strong multi-sector collaboration where sectors 'work hand in hand' or 'support each other' in addressing sexual violence. However, the case studies reveal different barriers and facilitators of the collaboration ideal that either enabled the integration centres to address victim needs and rights or fail to do so effectively.

[665] Interview with trauma counsellor Kitale GRC, February 2016.

The existence of integration at both institutional and systems levels, and not just service provider level, is a facilitator of multi-sector collaboration. For example, for the TCCs, several participants felt that the everyday interaction between multi-disciplinary teams of service providers such as health workers, police, lawyers and social workers was eased because multi-sector partnerships were already established at national levels before being cascaded to district level. One participant explained:

> It was at the highest level that it was negotiated, way above my pay grade. I think it was so important that it was at a that senior level that everything was sanctioned, because everybody kind of has a mandate to sit around the table…like, "my boss said it was okay, so now am sitting and talking to you because my boss said it is fine for me to do so".[666]

Therefore, multi-sector collaboration at the institutional policy level has a way of facilitating service integration at the service provider's level. In Kenya, one participant explained that the lack of a national strategy compromised effective service integration. She said:

> First of all, the work of this centre, if it was acknowledged by law or even just one policy document, I think it will work, because these things are pretty much about people, now who will take responsibility?[667]

In Kenya, the absence of such policy level integration strategy was a barrier that resulted in the weak referrals systems between health facilities and police. For example, in one centre, an NGO had taken responsibility to finance integration activities at service-provider level through infrastructural and capacity building. They purchased forensic kits to 'boost the GRC, and trained some nurses and doctors on how to use them.'[668] The NGO also integrated the police who 'had said they do not have anywhere to store the samples, so we bought them a fridge, and storage space to store the other evidences like clothes.'[669]

[666] Interview with forensic doctor SA.A.1 on 1st November 2016.
[667] Interview with key informant KE.KI.2 on 2nd Feb 2016
[668] Ibid.
[669] Ibid.

However, despite these infrastructural developments by the NGO, the forensic kits were still not in use, they were piled up in the storage room. Conducting the forensic examination remained a challenge because the health workers who were previously trained by the supporting NGO were rotated to other departments in the hospital. Transporting and collection of the forensic specimen to the forensic laboratory also remained a systemic challenge as the police said 'they can collect the samples from the centre, but who will facilitate the transport to take the forensic kits to Nairobi (the government chemist laboratory)?'[670] This experience shows that service provider referral networks will continue to struggle in the absence of collaboration at the institutional and systems levels between health, legal and justice sectors at national and provincial levels.

Other barriers emerging from these findings include weak referral linkages to specific service components, that is, with respect to legal services in Kenya, and psychosocial support for South Africa's TCCs. In addition, unequal sector involvement, as noted in the case of the TCC, is another barrier to multi-sector collaboration that compromised how DSDs shelters and social work services were integrated to support TCC victims.

The other facilitators arising from the findings in this chapter include linkages with community resources, such as community-based organizations, paralegals, and community health workers, which facilitate victim support even in the absence of professional services. The GBVRCs used community structures to facilitate follow-up of cases, to sustain contact with victims to identify their needs, monitor their progress and refer them for additional services needed. In addition, strategically organised periodic meetings were noted as a way of strengthening referral networks. As the case of Worcester TCC showed, the involvement of strategic individuals with decision-making powers in meetings strengthened sector collaboration allowing the TCC staff to negotiate for more health workers assigned to the centre.

5.11. Conclusion

[670] Ibid.

This chapter has described the structure and operations of service integration centres, including differences in collaboration systems, services provided and variations in different geographical settings from rural to urban settings. The integration centres aim to provide designated and specialised health, legal and psychosocial support services within designated safe spaces at mainstream service points. In both country contexts, multi-disciplinary teams of service providers collaborate to provide sexual violence services, but were constrained by limited training, infrastructural and human resource gaps, and limited options for referral especially for long-term victim support services. In both countries, these challenges were exacerbated in rural areas where the centres are more resource constrained.

South Africa's TCCs operate a systematised state-led approach providing emergency rape response services through institutionalised partnerships between different state departments, led by the NPA. Kenya's GBVRCs are practice-emergent, showing congruence in features, which operate as referral networks formed by partnerships mainly within the health sector. These integration centres also operate amidst multi-sector collaborations that exhibit barriers and facilitators that can enable or compromise the model's ability to meet victims' needs.

The chapter has also revealed that the TCC and GBVRC case studies operate different integration approaches inclined towards producing certain outcomes as a priority over others. While South Africa's TCCs operate the OSC approach designed to provide emergency services and improve criminal justice system outcomes, Kenya's GBVRCs facilitate referral networks primarily to improve comprehensive health outcomes, including long-term psychosocial support. In the following chapter I discuss how these emerging integration approaches are 'service orientations', which have implications for contributing towards or compromising the fulfilment of the state's obligations to exercise due diligence in addressing sexual violence.

CHAPTER 6

ORIENTATIONS MATTER: THE ROLE OF STAKEHOLDERS IN SHAPING NETWORK OUTCOMES, AND IMPLICATIONS FOR STATE OBLIGATIONS TO ADDRESS SEXUAL VIOLENCE

6.1. Introduction

Stakeholders within a multi-sector collaboration have the potential to influence their networks, in a way that shapes the design, nature and outcomes of the collaboration.[671] At the interplay of structures, processes and actors, different players can exercise their capacities to incline or orient the landscape of integrated service provision to prioritise certain outcomes over others.[672]

In this chapter, I argue that integration approaches are shaped by complex multi-sector collaboration processes, where the sectors and stakeholders involved wield their capacities and resources to influence the networks' outcomes. These influences cause the integration models to operate in a way that either contributes towards or compromises fulfilment of the state's obligations to address sexual violence. In the previous findings chapter, I showed the different integration approaches and collaboration systems emerging from the case study of Kenya's Gender based Violence Recovery Centres (GBVRCs) and South Africa's Thuthuzela Care Centres (TCCs).

South Africa's TCC model which is an emergency, integrated rape response model implemented through centralised and institutional multi-sector collaboration, focuses on

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[671] Burris, S., Drahos, P. & Shearing, C., above note 79 at 33. These scholars offer 'nodal governance' as a frame that elaborates contemporary network theories in social sciences which attempt to explain how actors within social systems interact to shape the network outcomes. See for example, Castells, M., *The rise of the network society* (2011); Castells, M., 'Materials for an exploratory theory of the network society' (2000) 51.1 *The British Journal of Sociology* 5; Scott, E. R., 'A decade of treating networks seriously' (2006) 34.4 *Policy Studies Journal* 589. At the core of nodal governance is a firm resistance to the pessimism that networks of collective action are too complex to understand, and to govern. This theory builds on to and is responsive to work of Friedrich Hayek which exposes limits of effective governance in complex social systems. See Hayek, F. A., *Law, legislation and liberty* Vol. 1: Rules and order (1973). Therefore Burris, Drahos and Shearing seek to unpack how complex multi-sector collaborations produce order by arguing that different actors in the networks as 'nodes' mobilize the knowledge and capacity of members to manage the course of events and influence on the networks.

[672] Vangen, S., Hayes, J., & Cornforth, C., above note 106 at 1246.

enhancing criminal justice system outcomes. The TCCs have strong systematic linkages to the police and courts with the aim of increasing conviction rates, but weak linkages to comprehensive health care including long-term psychosocial support. Conversely, Kenya's GBVRCs are practice-emergent models operating as referral networks facilitated through different state and NGO partnerships mainly within the health sector. While the GBVRCs, as independently established centres, vary in specific focus areas, such as the types of cases they focus on, a congruence can be discerned in that all the models seek to provide comprehensive gender-based violence services. The integration centres in Kenya focus on comprehensive health responses to sexual violence including treatment and psychosocial support, but have weak linkages to legal and justice sector responses.

This chapter discusses these different integration approaches as service orientations that emerge, based on how each actor or sector, as a node within the multi-sector networks, exercises their capacities to influence and shape the outcomes of service integration.[673] Orientations are inclinations, intentions, aims, or ways of operation that the integration models adopt in their functioning. Using insights from nodal governance[674] and collaboration theories,[675] I argue that the different actors involved in these integration models use their resources, mentalities (ways of thinking), technologies (or methods), and institutional structures (that mobilize resources) to produce orientations that shape the network outcomes.[676]

I begin the chapter by discussing the two main orientations that emerge, that is, the criminal justice system focused orientation of South Africa's TCC model and the comprehensive health outcomes orientation of Kenya's GBVRCs. I then discuss other emerging orientations which are common in both countries, albeit some reflecting stronger in one context than the other.

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[673] Nodes are points on or along networks which are 'sites of governance, where knowledge, capacity and resources are mobilised to manage course of events'. Burris, S., Drahos, P. & Shearing, C., above note 79 at 37.
[674] Holley, C. & Shearing, C., above note 79; Burris, S., Drahos, P. & Shearing, C., above note 79.
[675] Huxham, C. & Vangen, S., above note 189; Vangen, S. & Huxham, C., above note 193; Huxham, C. & Vangen, S., above note 87.
[676] Nodal theorists explain four characteristics of nodes: The mentalities are ways of thinking about the matters which the institutional actor in a network has emerged to govern. Methods involve set ways of doing, including technologies used to exert influence over the course of events. Resources exist to support the operation of nodes and institutional structures exist to enable mobilization of resources, mentalities and methods over time. Burris, S., Drahos, P. & Shearing, C., above note 79 at 37.

These are: emergency-focused responses with limited consideration for long-term support services, and response-oriented approaches with diminished focus and unclear strategies on prevention. Using a feminist human rights perspective, I argue that both criminal justice and comprehensive health outcomes, including psychosocial care, are essential to fulfil state obligations to address sexual violence against women. This analysis chapter contributes towards diffusing tensions in sexual violence service provision literature, which remains firmly divided between the camps of either public health (health systems) and legal (criminal justice) interventions research.

6.2. Orientation: Criminal Justice System Focused, With Diminished Attention to Comprehensive Health and Psychosocial Support

A functional and effective criminal justice system that is sensitive to handling sexual violence cases is critical to the fulfilment of state obligations to address sexual violence.[677] Multi-sector collaboration between the health sector and the criminal justice system facilitates timely processing of forensic evidence and filling in medico-legal documentation to strengthen investigation and increasing chances of successful prosecutions. In this way, integration models can contribute to the fulfilment of state obligations to prosecute and punish sexual violence. In addition, the coordination between health care providers, social workers, police and prosecutors can reduce the number of people to whom victims have to recount the traumatic experience of violence. This reduces chances of secondary victimisation, which contributes to fulfilment of the state obligation to protect. [678]

In terms of criminal justice, a 'good outcome' for an integration project, from a feminist human rights perspective, is one that holds perpetrators of sexual violence accountable, while promoting the safety and empowerment of victims. This requires an approach that manages any risks the victim may be exposed to when choosing to pursue criminal justice.[679] It includes

[677] United Nations General Assembly, resolution on strengthening crime prevention and criminal justice responses to violence against women General Assembly Resolution, March 2011, A/RES/65/228. This resolution provides that states are required to invest adequate resources towards violence against women response including having specialised response units at the police and courts, having trained personnel at both pre- and post-court processes to avoid bias and stereotypes that blame victims. This includes having comprehensive legal aid policy and effective coordination between service providers.
[678] Abdul Aziz, Z. & Moussa, J., above note 47.
[679] Ibid.

using resources of the collaboration network to respond to other multiple complex victim needs such as safety, health and psychosocial support. It also includes fulfilling other rights of victims, such as right to give and receive information as the case progresses, and to access other forms of redress.[680]

South Africa's TCCs operate within multi-sector collaborations that integrate services at institutional level. These institutions have mentalities that have shaped the development and operations of the TCCs, including the positioning of the National Prosecuting Authority (NPA) as the lead agency or governing node. The TCC integration project was established as a 'critical part of South Africa's anti-rape strategy, aiming to reduce secondary victimisation, improve conviction rates and reduce the cycle time for finalisation of cases.'[681] The thinking that drove the establishment of the TCC integration project is that of responding to sexual violence through criminal justice.

Feminist scholars are critical of the role of law, especially criminal law in deterring or delivering justice for violence against women.[682] These critiques question the centrality of criminal justice in violence against women response. Multi-sector approaches have the potential to displace the centrality of criminal justice, because as different sectors respond jointly, a platform is created for the multiple needs of sexual violence victims to be identified and addressed.

6.2.1. Politics of Lead Agencies in Shaping Service Orientations

With the NPA as the lead agency for South Africa's TCC model, it is not surprising that the focus of the integration model is to improve criminal justice system outcomes. The NPA acts both as oversight and management of the TCC model, as one participant explained:

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[680] Manjoo, R., above note 336 at 27.

[681] South Africa NPA TCC blue print, above note 43.

[682] For example, Sidner has critiqued the centrality of criminal justice and the focus on prosecution and punishment, over amelioration, alternative models to redress victims and prevention of violence against women. Snider, L., 'Towards safer societies: Punishment, masculinities and violence against women' (1998) 38.1 *The British Journal of Criminology* 1 at 2; Smythe and Artz's analysis of the value of criminal law responses to sexual violence shows that criminal justice is useful only if understood not as unilateral process, 'but as part of larger process of transformation and protection, while acknowledging that sexual offences against women have previously been excluded in legal discourse.' Artz, L. & Smythe, D., above note 69 at 17.

> So, we as the NPA, we basically have a supervision kind of role, within the whole model, so the NPA is responsible for the management of the services rendered to gender-based violence victims, what makes the TCC unique is that link with the court.[683]

While the NPA works in partnership with other sectors, such as Department of Health (DoH) and Department of Social Development (DSD), it is clear that the mandates of the TCC model considerably reflects the mandate of the NPA as the lead institution. Participants from the NPA often discussed the stakeholder partnerships as existing for purposes of enabling the NPA to fulfil their institutional mandates. For example, one participant noted:

> Even though NPA is responsible for driving the whole sort of process we cannot operate outside of a healthcare facility because we need the medical and healthcare examiners to actually examine the patients to record their findings, to do the forensic medical examination, because it is eventually going to help us when the matter does go to court.[684]

While this participant is explaining the value of stakeholder collaboration, it is interesting that this partnership is described in terms of how the DoH enables the NPA to achieve its objectives and concerns. Vangen et al explain that this form of governing collaborations, where there is an overt lead agency, tends to shift power to the lead agency, in terms of making both strategic and operational decisions.[685] Hence the collaborative advantage, being pursued in the TCC integration model, that is, goals or objectives which cannot be attained by any one sector working alone,[686] becomes the objectives of the NPA as the lead agency.

Having lead agencies does not necessarily mean the collaboration goals cannot include multiple interest, concerns and objectives of other sectors or stakeholders. Vangen and Huxham draw a distinction between a more facilitative form of leading collaborations, which

[683] Interview with case manager SA.C.3 on 15th March 2017.
[684] Interview with key informant SA.KI.1 on 16th May 2017.
[685] Vangen, S., Hayes, J. & Cornforth, C., above note 106 at 1241.
[686] Vangen, S. & Huxham, C., above note 98.

fosters the 'spirit of collaboration', by involving and embracing the other sectors' concerns.[687] They contrast this with 'collaborative thuggery' which, though not literal, is the antithesis of the former, reflecting a more pragmatic approach to define realistic goals that are achievable. This pragmatic approach focuses on efficiency rather than effectiveness, through mobilizing capacities of other sectors, to enable the lead sector in achieving their key mandates. The consequence of the latter, which is what the TCCs reflect, is that while the resources and capacities of other sectors are mobilised to align to the lead sectors' concerns, other sectors' goals are diminished.

Diminishing the roles of other sectors creates power hierarchies that affect service provision because the other sector stakeholders end up not taking ownership of the integration project.[688] Lack of joint ownership of the collaborations' visions or objectives further diminishes the presence and involvement of other sectors, and by extension their services as well. The question of who owns the integration project is linked to issues of accountability and taking responsibility for provision of services. [689] For example, as earlier noted, while South Africa's DSD forms part of the partnering institutions in the TCC network, they are not equally involved in TCC operations.[690] Consequently, the DSD did not take any ownership of the TCC network or collaboration processes. When I asked one participant from DSD to describe how they work with TCCs, she noted:

> I will not feel comfortable talking about their (NPA and DoH) models, you must talk to them about their models. It's not that I don't know, it's just that I feel it's not right that somebody else talks about somebody else's model.[691]

Interviews also showed that the DSD has different ways of thinking about what the concerns and objectives of such an integration model should be. As I asked this participant what their stakeholder role is, outside of the criminal justice system focused objectives spearheaded by the NPA, she responded:

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[687] Vangen, S. & Huxham, C., above note 193.
[688] Colombini, M., Dockerty, C. & Mayhew, S., above note 30 at 194.
[689] Artz, L., Smythe, D. & Leggett, T., above note 50.
[690] Interview with key informant SA.KI.2 on 16th November 2016.
[691] Ibid.

> Okay, now you are talking my language, I'm a strong believer of restorative justice and the core of restorative justice is being victim centred. Unfortunately, I think often our legal system is based around the availability of the perpetrator, it surrounds the alleged perpetrator…so I think that is the only way, if we really embrace restorative justice. We should not make the victim an afterthought, I think that is the key thing.[692]

Studies on interagency collaboration discuss how conflicting and often competing sector mandates are a barrier to service integration because it is difficult to satisfy competing agendas.[693] Such conflict is rooted in different professional knowledge domains and boundaries, which result from differing theoretical bases, resulting in conflicting aims and expectations.[694] It becomes difficult for sectors with such conflicting ideologies to share objectives and concerns on how to jointly respond to sexual violence.

Differences in sector mandates can slow down and compromise positive collaboration outcomes, that is, a holistic response to legal, health and psychosocial support to victims. For instance, referrals for shelter and counselling services is one disjuncture in the TCC model. As described earlier, while the NPA's service providers raised the challenges of lack of shelter services,[695] the DSD noted that the TCCs do not form part of their major referral partners to the shelter services that they provide.[696] This disconnect between the need for and access to shelter services is a result of fragmented interventions due to unequal involvement of relevant sectors, although other supply and demand factors for these services have an influence too.

This disconnect compromises the process of linking victims to mid- to long-term social support services, which is already a process that can be very slow, at best, and impossible, at worst. Therefore, the politics of lead agencies, in this case the NPA, and the unequal involvement of relevant sectors, such as the DSD, in multi-sector collaborations, facilitates the criminal justice

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[692] Ibid.
[693] Darlington, Y., Feeney, J.A. & Rixon, K., above note 116 at 1098.
[694] Ibid,
[695] Interview with victim assistant officer SA.D.4 on 17th November 2016.
[696] Interview with key informant SA.KI.2 on 16th November 2016.

focused orientation of the TCCs. While this orientation is designed to generate a more effective response to criminal justice, the failure to adequately integrate critical social services eclipses the comprehensive psychosocial needs of sexual violence victims.

6.2.2. Institutional Structures, Human Capacity and Entry Points Matter

The TCC operates amidst a number of other institutional structures, which mobilize resources to enable the TCCs to improve criminal justice system outcomes as a key indicator of success. These institutions include the Sexual Offences and Community Affairs (SOCA) unit which is a key structure in mobilising resources and personnel, such as specialised prosecutors and case managers to follow up TCC cases in court.[697] In addition, the specialised sexual offences courts, and specialised police investigation unit are structures linked to the TCCs through which resources are mobilised to increase conviction rates.[698]

Through these institutional structures, capacity-building resources are mobilised to train service providers and provide specialised services, enabling the TCC model to contribute towards fulfilment of state obligation to prosecute and punish sexual violence.[699] This includes training TCC personnel on the social context of rape, including 'how to treat victims of gender-based violence.'[700] Such training facilitates positive victims' experiences within the criminal justice system.[701] The system-level integration of institutional structures involved in the TCC also creates an effective system of referral between health facilities, police and courts, which eases the process of completing medico-legal documentation and maintaining the chain of forensic evidence.

The choice of investment focus, in terms of which human resource is capacitated within the TCC, shows which personnel are seen as central to the functioning of the model. The NPA invests in three major, full-time personnel positions; the case manager, the site coordinator

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[697] Muller, K. D. & Van der Merwe. A., 'The sexual offences prosecutor: a new specialisation?' (2004) 29.1 *Journal for Juridical Science* 135.

[698] The NPA reported that it exceeded its conviction target rates of Thuthuzela Care Centres cases through sexual offences courts with a rate of 71 per cent which is significantly higher than the target of 67 per cent. Department of Justice and Constitutional Development *Annual Report 2016/17*, 2017 at 111.

[699] Abdul Aziz, Z. & Moussa, J., above note 47.

[700] Interview with key informant SA.KI.3 on 6th June 2017.

[701] Smythe, D., Artz, L., Combrinck, H. et al., above note 69.

and the victim assistant officer. Together, these three roles work to ensure a seamless link between the TCCs and the court, as one case manager explained:

> The link with court. That is a unique thing about this Thuthuzela Care Centres, and I know when they say at a global level what makes this different, it is the link with court. That is the link with everything we do between the centre and the court.[702]

The case manager is a legal officer that provides support during the police investigation process which is critical in strengthening evidence. This includes strengthening victim's statement because 'often the statement was taken under traumatic circumstances so mistakes could have been made, and maybe there is other information she (victim) can give'.[703] This prioritisation of investment towards linkages with court structures further inclines the TCC model towards the criminal justice system orientation. The service linkages between these three key personnel decreases chances of attrition of cases from the criminal justice system, which further contributes to fulfilment of state obligation to prosecute and punish sexual violence. [704]

The main entry point of the TCC, as conceptualised by design, is also telling in terms of which cases the TCC is most responsive to, and what the model's outcome priorities are. The police station is the main entry point into the TCC integrated service. Several participants explained that a majority of the TCC cases are cases that are reported first to the police, then the police brings the victim to the centre. Similarly, the TCC blueprint describes the typical flow of cases into this model as starting from the moment when a rape victim 'reports to the police station, after which she is moved to a more victim friendly environment before being transported by police or an ambulance to the Thuthuzela Care Centre at hospital'.[705]

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[702] Interview with case manager SA.C.3 on 15th March 2017.
[703] Ibid.
[704] Attrition studies show that rape cases often drop out of the system at the early stages before referrals to the prosecutors. Artz, L. & Smythe, D., above note 38. Therefore, the three core TCC personnel's focus on supporting cases at the early stages of reporting by linking them to prosecution process has the potential to keep cases in the system. Artz, L. & Smythe, D., above note 38.
[705] South Africa NPA TCC blue print, above note 43.

Having the police as the main entry points to the TCCs, on the one hand, speaks of the existence of an effective emergency response, which links victims to other needed services promptly after reporting. However, it also raises the question of how the TCC model responds to other pathways through which victims of sexual violence seek support.[706] South Africa's studies on rape reporting have shown that few victims of sexual violence report to the police first, if at all.[707] While the police are not the most probable place a victim will report first, it is indeed the entry point to the criminal justice system. Therefore, the TCCs entry point design that focuses on cases reported at the police further orients the model towards improving criminal justice system outcomes. For a service integration approach, this design is not as responsive to victims who do not report to the police. It eclipses the needs and rights of victims using other pathways to disclose, seek recourse and other support services.

6.2.3. Diminished Attention to Comprehensive Health Care Including Psychosocial Support

While a multi-sector approach that strengthens criminal justice response is critical, the unilateral focus on prosecution has the potential to de-centre and eclipse other victim's needs and rights. A victim-centred integration approach requires an assessment of victims' other needs such as health and psychosocial, coupled with equal investment in a process of using its network resources to meet these needs.[708] Such a balanced coordination offers more women the option to break the cycle of violence, prevent its re-occurrence, challenge the underlying risk factors and treat both mental and physical trauma through medium- and long-term measures. Manjoo argues that the individual level due diligence responsibility of states should ensure victims are not only having access to criminal justice but are able to transition out of violent situations to rebuild their lives.[709]

Therefore, TCCs' diminished attention to provision of comprehensive health and psychosocial services compromises fulfilment of state obligations to protect, prevent and provide

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[706] Rape victims report at other service points and take different pathways depending on factors such as accessibility, availability and acceptability of formal or informal justice systems. Logan, T. K., Evans, L., Jordan, C. et al., 'Barriers to services for rural and urban survivors of rape' (2005) 20.5 *Journal of Interpersonal Violence* 591.

[707] Victims are more likely to first tell a family member at 41 per cent then report to other sources at 18.8 per cent and the to the police at 17.7 per cent. Machisa, M., Jina, R., Labuschagne, G. et al., above note 33 at 55.

[708] Keesbury, J., Onyango-Ouma, W., Undie, C. et al., above note 56.

[709] Manjoo, R., UN Doc A/HRC/23/49/2013, above note 80.

adequate redress for victims of sexual violence. For example, while the TCC database facilitates flow of information between the victim and the criminal justice system, this method or technology is designed to only track the progress of criminal justice outcomes. [710] There is no similar method for tracking access to other integrated services such as health and psychosocial support.

As such, while it is possible to know the status of a case being prosecuted, it is not possible to know status of referrals for services such as continued counselling, shelter, safe houses, or additional health services. As the previous findings chapter showed, referrals to other support services are piecemeal, they are done in a generalised way, not as formalised or systematised as referrals to the police and courts.

Also noteworthy is that in terms of personnel, there is significantly less resourcing in terms of providing health workers, counsellors and social workers at the TCCs. This compromises provision of these other services including follow up for medical treatment and counselling services. Other stakeholders such as volunteer counsellors felt that they were treated as auxiliary staff, with their ideas and concerns on how to improve the service not being given serious considerations. For example, one counsellor noted that she started a victim support group to facilitate long-term support, however, this initiative failed because the TCC stakeholders were not able to facilitate transport costs for victims.[711]

Vetten has similarly found that that the TCCs' psychosocial support component is compromised because counsellors remain 'the lowest-paid category of workers in the TCC, having the least status and authority, considered low-skilled, which leads to confusion around their role in the TCC, with low value placed on their contribution'.[712] A recent audit of TCCs nationally has similarly shown that the TCC model is failing in facilitating provision of psychosocial support due to contestations among the stakeholders in terms of who is

[710] Interview with site coordinator SA.A.3 on 3rd November 2016.
[711] Interview with lead counsellor SA.D.2 on 17th November 2016.
[712] Vetten, L., above note 53.

responsible.[713] While some expect the DSD to provide it, others maintain that since the centres are located in public hospitals, it is the responsibility of the DoH.[714]

This section has shown how institutional structures, methods and resources, including the politics of lead agencies operate to shape the priority outcomes of the TCC. While the TCC model contributes significantly to fulfilment of state obligations to prosecute and punish through criminal justice, it compromises fulfilment of the obligations to protect, prevent and provide adequate redress for sexual violence due to diminished focus on comprehensive health care including psychosocial support.

6.3. Orientation: Comprehensive Health and Psychosocial Support Focused, with Diminished Attention to Legal Sector Responses

Since Kenya's GBVRCs are established independently, emerging from practice-based partnerships between different state, and non-state actors, there is no overt lead agency. However, since most of these partnerships are primarily among agencies or stakeholders within the health sector, the health sector takes subliminal lead in service integration. Huxham and Vangen describe how governance of collaborations can be shaped insidiously, even in the absence of lead agencies by external forces such as funding processes and structures.[715] They argue that processes such as 'committees, workshops, seminars and emails are avenues through which collaborations' communications take place' to form partnerships and construct collaboration agendas.[716]

Institutional structures that have been at the forefront of defining the processes of sexual violence management in Kenya have done so through such processes of workshops and setting up committees. [717] These processes have been led by the Ministry of Health, Division of Reproductive Health and the technical working group on Gender and Sexual Reproductive Health and Rights, which saw the development and revisions to the national guidelines on

[713] Jordaan, S., Slaven, F., Louwrens, C. et al., above note 49.
[714] Ibid.
[715] Huxham, C. & Vangen, S., above note 87.
[716] Ibid
[717] Kenya Sexual Violence National Guidelines, above note 4.

management of sexual violence across sectors.[718] These policies, and strategies were established with significant participation of NGOs focused on health systems.[719] These processes have shaped donor funding streams and priorities leading to significant investment in comprehensive health care, which includes psychosocial support services. As described earlier, the four GBVRCs I studied are funded in one way or another through these partnerships. All of them exhibited congruence in terms of providing comprehensive health care including psychosocial support.

In this regard, Kenya's GBVRCs integration is focused on medical treatment and counselling services. Health providers in all four centres took medical treatment, especially follow up for Post Exposure Prophylaxis (PEP) medication seriously, often integrating the treatment plan with counselling sessions, to ensure victims come back. For example, one forensic nurse said, 'we give counselling that continues for quite some time … and they will continue with it many times for a period like six months because we want to follow up on HIV testing.'[720]

All the four GBVRCs used the method of counselling through victim support groups which ensured that there are strong sustained contacts between the centres and the victims for a period of eight months to one year.[721] In addition to the victim support groups, victims received a minimum of five to six counselling sessions, with individualised follow up for a period of five to six months, in addition to the support groups. These counselling sessions could continue, based on the victim's needs, as one participant explained:

> There are the long-term measures, especially for sexual violence we follow up most of them for 6 months, but a few according to their conditions, counselling may continue indefinitely until we feel that the client has been rehabilitated.[722]

However, as noted earlier, due to the challenges of human resource and the lack of training with centres in specialised facilities benefitting from access to more quality service than

[718] Ibid.
[719] Ibid at ix.
[720] Interview with nurse KE.C.1 on 21st January 2016.
[721] Three centres facilitated the support groups for one year and one for eight months.
[722] Interview with clinical officer 7th Feb 2016.

centres at primary, district level facilities, counselling services differed. Contrary to South Africa's TCCs approach, these follow-up strategies were implemented institutionally within the centres and were available to all victims visiting the centres, regardless of whether their cases were being prosecuted or not.

A key mentality driving health systems responses to sexual violence is the increasing recognition of violence against women as a public health concern. Over the last three decades there have been escalating calls for improving health systems responses to violence against women to address both short-term and long-term health consequences.[723] Studies on violence against women in Kenya have especially focused on health consequences of intimate partner violence including physical, mental and reproductive health.[724] These studies have focused on analysing GBVRCs service integration within the rubric of improving comprehensive post-rape care (PRC) services. The PRC services discourse is primarily concerned with how the health sector collects and delivers forensic evidence to support the investigation process. The result of having this discourse informing sexual violence service integration is that the focus remains on clinical case management, treatment protocols and completing medico-legal forms.

The challenge with these mentalities is that they operate a system-centred approach where the health systems try to ensure they have fulfilled their mandates in terms of clinical case management. This is dangerous because it can lead to medicalisation of sexual violence where violence against women is no longer addressed as a human rights violation but a matter of treating injuries and managing health consequences.[725] On the contrary, a victim-centred integration approach rather asks, how the sectors can collaborate to jointly respond to multiple needs of a sexual violence victim, which may exist well beyond case management.

[723] Krug, E., Dahlberg L.L., Mercy J.A. et al., above note 88.
[724] Kilonzo, N., Molyneux, S., Taegtmeyer, M. et al., above note 191; Kilonzo, N., Taegtmeyer, M., Molyneux, C., above note 64; Fonck, K., Els, L., Kidula, N. et al., 'Increased risk of HIV in women experiencing physical partner violence in Nairobi, Kenya.' (2005) 9.3 *AIDS and Behavior* 335.
[725] Miller, A., above note 66.

This section has shown that through provision of comprehensive health care and psychosocial support, Kenya's GBVRCs facilitates healing from trauma, provides support structures for the well-being of victims and enhances safety due to consistent follow up. In this way, Kenya's GBVRCs contribute to fulfilment of state obligations to prevent (secondary) and protect sexual violence by incorporating measures to identify when the victim is in a risky situation and to intervene which can avoid re-occurrence. However, the institutional and policy focus on clinical case management and the primary reliance on shifting and unsustainable NGO project funds for psychosocial support, compromises the fulfilment of these same state obligations.

6.3.1. Disconnect with Legal and Justice Sector Responses

Viewed as medical treatment, victims' healing and well-being emerged as the main discernible goals of Kenya's integration centres, resulting in the increased diminishment of the roles of the legal and justice sectors. For example, service providers often reiterated the value and importance of a victims' overall well-being over the tedious legal proceedings, as the quote below illustrates:

> If the legal sector is failing, we tend to focus on the survivor, we try to make them shift the focus from concentrating so much on the legal proceedings and the perpetrator, to focusing on themselves and getting healed, because that's the most important thing. We tend to address on the survivors' wellbeing. We shift the focus to the survivor because at the end of it, we want them to heal. [726]

This disconnect is a barrier that exists because of the lack of institutional collaboration at a systems level. As noted earlier, the GBVRCs had no institutional structures funding the integration of legal services, or linkages with the police and courts. Linkages with these legal sectors depended largely on the stakeholders' participation in broader, regional collaboration networks. These networks are loose forums, with open invitations to all stakeholders in gender-based violence work, where different providers interact and share ideas on how to deal with difficult cases, as this participant explained:

> We have a GBV working cluster group which comprises people from the government sector and NGOs where we have a monthly meeting. It is in that meeting that we share

[726] Interview with counsellor KE.A.3 on 3rd February 2017.

> information and, in the event, that we, the police, might need somebody to assist like maybe the issue of social work, we normally source from that GBV working cluster, because you know who to contact.[727]

These forums were considered as one facilitator for integration because of the contacts shared. However, while such loose forums may forge partnerships, they cannot be considered as platforms where services are integrated. Vangen argues that such open structure collaboration systems can be a barrier to integration because it is difficult to set a concrete implementation agenda, to co-ordinate action, especially when stakeholders 'are allowed to dip in and dip out'.[728]

This disconnect from the legal and justice sectors leads to weak referral systems between health and legal sectors, placing undue burden on victims when moving between the different health and justice sector agencies. This victim burden was especially evident when it came to the filling in of the P3 medico-legal form.[729] One victim explained how she had to travel between the police stations and hospitals to get the forms filled in, causing delays and frustrations that caused her to give up the reporting process. She explains the challenges of the tedious journey to get the P3 form filled:

> I tried, I went to police station, and I was not really helped. I left there and went to traffic police – (where the P3 forms are usually filled by the police surgeon). When I arrived, I was already number seventy something in the queue. By 9:00 am the office calls me asking aren't you coming to work? I told the person who was in charge there that I cannot stay any longer, let me just go. The next day I went back to the police and found a lady who said she will contact me soon. I did not hear from her. I went back and there was another police officer at the station. He told me did you give away the original copy of your form that the doctor had stamped? You should have photo

[727] Interview with police KE.C.4 on 21st January 2016.
[728] Huxham, C., Vangen, S. & Eden, C. 'The challenge of collaborative governance' (2000) 2.3 *Public Management an International Journal of Research and Theory* 337 at 341.
[729] Both the P3 form and the PRC form are required to be filled in the case of sexual violence with the P3 being the general form filled in care of any violent crime at the PRC being the specific sexual violence form.

> copied at least two copies one for you and another for the hospital. So, I just gave up.[730]

This account captures the experience of one victim who tried to report her case to the police, which requires the filling in of the medico-legal forms by three different stakeholders, the medical officer that first examined the victim, the police officers and the police surgeon. This victim explained that this tedious journey took her five days of moving from one point to another, after which she gave up. Her experience reveals how this disconnect from the legal and justice sectors can compromise the process of investigation and criminal justice. Most sexual violence victims in Kenya expressed that what they still needed after being supported at the centres was support with the police, legal aid and representation and court processes.

In one discussion, one participant said that what she felt she still needed after receiving services was 'mostly on the part of the court. If there was a way to have lawyers who will help us offered by the government, it should not be that it is me who is paying out of my pocket to pay them.'[731] All other eleven participants in the discussion agreed with her. Another participant in the same discussion then said:

> I will also say the way the others have said. It will be good to get legal help because that is where the challenge is. Because as we have spoken today we will keep being afraid of the men, and yet the men will not see as though what they did was bad.[732]

Therefore, while this service orientation that focuses on comprehensive health care and psychosocial support contributes to fulfilment of the state's obligation to prevent and protect sexual violence, it is not enough. The sole focus on improving health outcomes de-centres other needs and rights of sexual violence victims, such as access to criminal justice, holding the perpetrators accountable and other forms of legal redress. In this way Kenya's integration models compromised fulfilment of the state's obligations to prosecute, punish and provide adequate redress for sexual violations.

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[730] Group interview with sexual violence victims KE.B.1 on 7th June 2016.
[731] Group interview with sexual violence victims KE.D.6 on 5th Feb 2016.
[732] Ibid.

6.4. Orientation: Emergency/ Crisis-focused Response, with Diminished Long-term Support

The state obligation to protect encompasses the provision of timely and adequate support services to victims of sexual violence in a way that enhances safety and prevents re-occurrence.[733] However, when integrated service provision stops at emergency response, without consideration for long-term care, the victims' safety and overall well-being is compromised. The state responsibility to exercise due diligence in prosecution, punishment and provision of redress requires victims to receive continued social, psychological and legal assistance since women who disclose violence are at risk of re-victimization.[734] In this section, I discuss how stakeholders have applied their resources, mentalities and methods to orientate integrated service provision as emergency care with little consideration for long term support. With South Africa's TCCs model being focused on criminal justice system outcomes, most participants described the TCCs role as fully discharged once the crisis services have been provided and linkage to the court is facilitated. Long-term psychosocial support was left to the chance that other sectors in the network will take responsibility. This quote illustrates this rather vague hope for long term support:

> That is why we refer outside to hand it over to the other NGOs to maintain the emotional aspect of it. Because we, containment is all that we can provide. That's why we have a network, the survivor still is within the system and we hope that she accesses it. [735]

The TCCs containment counselling approach shows the crisis-oriented nature of the psychosocial support component of this model. Most participants explained that containment meant quite literally 'to contain the client and also just to explain the (medical) procedure, exactly what is going to happen, and to say to them it is also a safe space created here for them'.[736] This counselling was generally described as a few minutes session to calm a frantic victim at the moment of first reporting, before medical examination. However, one of the four TCCs was different in that they incorporated additional counselling sessions as one

[733] Abdul Aziz, Z. & Moussa, J., above note 47.
[734] Manjoo, R., 84 at 257.
[735] Interview with victim assistant officer SA.B.4 on 26th March 2017.
[736] Interview with SA.B.1 on 23rd March 2017.

participant explains 'what I do is counselling the victims and we are based here. After seeing the victim, we set new dates for counselling and we follow up for counselling sessions.'[737]

As with psychosocial support, the provision of medical services at the TCCs during the first visit is comprehensive. However, beyond the first visit, the lack of sustained contact and follow up for victims, compromises continued access to health care, such as ensuring adherence to PEP dosage.[738]

Kenya's integration models were also understood as emergency service centres that are points of referral for more long-term care services that the victims may need. However, the GBVRCs used the victim support groups as a follow-up strategy or methods, which ensured sustained contact with victims. In this way the centres facilitated victims' access to subsequent services and monitored their mid- to long-term wellbeing.

6.4.1. Contrasting Mentalities on Victim Follow Up: Enabling Victims' Agency or Passive Government Response?

Service providers expressed different ways of thinking on the issue of follow-up services and sustaining contact with victims. Some participants thought that rather than doing follow up, service providers need to trust in the process of empowerment and victim's agency; that victims will take up referral services, should they wish to. This mentality is content with emergency response. The expectation is that victims will pursue additional support when they need it. For example, one TCC victim assistant officer said:

> Follow up is going to be difficult and also we don't have permission as from a survivor to contact her again to continue checking up. Thuthuzela is helpful, but it's also a painful memory for most of our survivors. Help will always be available to them, but, to go back and track them it's another logistic on its own …so you have to trust the process of empowerment that you have given the survivor enough resources to access information, and wherever she went for the ongoing counselling, that is where we are hoping that empowerment took place.[739]

[737] Interview with counsellor SA.D.3 on 16th November 2016.
[738] Jordaan, S., Slaven, F., Louwrens, C. et al., above note 49.
[739] Interview with victim assistant officer SA.B.4 on 26th March 2017.

This mentality underscores the value of victim empowerment and agency in seeking help and support. However, this way of thinking leaves room for assumptions that long-term support may not be as necessary or always needed by victims. In another TCC, a contrasting mentality emerged which views follow up as part of pro-active response to ensure the victim's needs are met. One victim assistant officer exemplifies this in her approach. She said:

> I am constantly in contact with my complainants or my survivors. I need to follow them up to find out what is the hold up with people like social workers. So, I contact them and then I talk to the complainant, and then they feel okay, you know, that support is there.

This way of thinking shows a deliberate pursuit for long-term follow up, using available capacity and resources, which is contrary to the previous mentality that is more passive. Kenya's GBVRCs displayed mentalities similar to the latter as exemplified in this statement by one participant:

> We do a follow up because we want to find out what is happening: how are they reacting to the drugs, are they coping? How are they emotionally coping with the problem? For us here, it is very, very essential.[740]

These contrasting opinions show that it is not always limited resources and capacity that determined whether stakeholders will follow up, sustain contact or offer long-term victim support. The stakeholder mentalities determine whether integrated services will operate with or without the intention to pursue long-term victim support services. While a victim's agency to determine whether or not they require subsequent contact should not be underestimated, that mentality may justify the lack of investment in follow- up and long-term care. Adopting the general approach to not sustain contact with victims because they *may* not want to be contacted, means that the victims who may need to be contacted and facilitated to access other long-term care will not receive such support. To fulfil the state obligations to protect, support services should be available to victims readily. This requires the government to

[740] Interview with social worker KE.A.7 on 27th Feb 2017.

provide these support services pro-actively and adequately, rather than putting the onus on victims to pursue such support services. [741]

6.4.2. Challenges of Resources, Methods and Institutional Structures for Long-term Support

The NPA's resourcing of the TCCs, which prioritises improved criminal justice system outcomes is not at odds with this emergency, rather than long- term, service orientation. The criminal justice system peripheries the victim of crime, whose role in the system is seldom regarded, beyond that of a prosecution witness.[742] The TCC model's method of follow up is largely limited to tracking victims whose matters are under investigation or being prosecuted. However, keeping track of a criminal case does not necessarily mean long-term support for the victims of crime. For example, continued counselling was often provided for victims whose cases are being prosecuted for the main purpose of strengthening the victim's confidence as a prosecution witness.[743] But what happens in instances where victims are no longer needed as a prosecution witness? Or where their statements are accepted on record as documentary evidence? What incentive remains to provide continued psychosocial support or to sustain contact?

In adversarial systems, the degree of involvement for victims in criminal justice shifts depending on whether the prosecution sees any utility for her in strengthening the state's case as a witness.[744] Therefore sustaining contact with victims and offering continued support primarily to improve criminal justice outcomes is a conditional form of long-term care. It is conditioned because it is only available to victims in so far as the criminal justice system finds them useful to build the prosecution case. This orientation eclipses the long-term support needs of victims whose cases are not being prosecuted and those who, are complainants, are not needed to the strengthen prosecution case.

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[741] Faull, A. & Mphuthing, P., 'Victim Support' in Gould, C. ed., *Criminal (In) Justice in South Africa: a civil society perspective* (2009) 124.
[742] Ibid.
[743] Interview with lead counsellor SA.D.2 on 17th November 2016.
[744] The prosecution represents the State's interest and is not a legal representative for the victim. 'Moving beyond 30 years of Anglo-American rape law reforms: Legal representation for victims of sexual offences' (2005)18 *South African Journal of Criminal Justice* 167.

Kenya's GBVRCs have a stronger long-term support component, implemented through victim support groups and linkages with community resources. Through linkages to other community-based organisations, victims who exit the support groups also began subsequent victim groups in their areas. The findings chapter also shows that GBVRCs were also firmly linked to community health workers, paralegals, schools, chiefs, shelters and children's officers at local levels. These structures are avenues through which cases are referred to the centres, as well as platforms through which the centres sustain contact with victims for long-term support.

However, like the TCCs, the GBVRCs lack sustainable channels of financial and human resources to sustain long-term support processes. The GBVRCs relied heavily on victim support groups using the infrastructure and staff at the health facilities. However, the dependence of shifting NGO project funds to run the monthly victim meetings compromised the process of effectively implementing this method as a long-term strategy. In addition, since these services were offered at the centres, they are accessible often only to victims within reasonable proximity to the centres, making follow up difficult for most other victims.

6.5. Orientation: Response Focused, Diminished and Unclear Strategies on Prevention

South Africa's TCCs and Kenya's GBVRCs are mainly service provision centres, supporting sexual violence victims after the violence has occurred. As such, they can be perceived solely as response interventions with no prevention components.[745] However, interviews with participants revealed different ways in which these integration approaches contribute towards fulfilment of the state obligations to prevent sexual violence. Assessing how response interventions contribute to prevention is quite an anomaly given the context that 'response' and 'prevention' are often pitted as extreme opposites, even mutually exclusive, in violence against women research and program work. In a recent review of how response interventions may contribute to preventing violence against women, Jewkes and Fulu found that the

[745] Unless otherwise specified in this section, I use the term prevention to mean secondary and tertiary forms of prevention, which as earlier noted in literature, are the forms of prevention that these service centres engage in.

evidence from existing studies is inconclusive.[746]These scholars found that, of the eleven studies on integrated sexual violence response interventions reviewed, none of the studies evaluated integration approaches in terms of how they facilitate prevention.[747]

The due diligence analysis framework considers prevention and response as part of a continuum, one leading to, or affecting the other through overlaps in the causes and consequences of violence against women. Therefore, my analysis included questions on prevention to understand how the operations of Kenya's GBVRCs and South Africa's TCCs are contributing towards prevention. The findings show that in both countries, the integration centres engage in prevention-related activities, however, due to the lack of clear strategies and structures to mobilize resources for the prevention components, the models become more oriented towards response.

South Africa's TCC model was born out of 'an urgent need for an integrated strategy for prevention, response and support for rape victims'.[748] While the prevention element was included in the integration projects' conceptualization, interview participant opinions were divided both in terms of whether the TCC model contributes to prevention, and if so how. Some participants, especially at management level, unequivocally explained that the TCCs play a key role in prevention, as this quote exemplifies:

> Definitely, and I think prevention is seen in the awareness raising activities of the TCCs. Our Western Cape TCCs are very big on awareness raising and going out into the communities and even in the hospitals where they are based. Our TCCs are very big on that and we encourage that as part of the key performance activities that they need to deliver on awareness raising, public legal education and the like.[749]

However, contrary opinions were expressed by other service providers, who explained that although the TCC model has a prevention mandate, it is significantly under resourced and

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[746] Jewkes, R., Hilker, L., Khan, S. et al., *Response Mechanisms to Prevent Violence against Women and Girls Evidence Reviews - Paper 3* (2015).
[747] Ibid.
[748] South Africa TCC Blueprint, above note 43 at 2.
[749] Interview with key informant SA.KI.2 on 16th November 2016.

therefore hardly implemented. These participants expressed a measure of anxiety and frustration because they were expected to report on prevention-related activities as part of their performance indicators, yet there were no resources or strategies to implement these activities at local level. For example, one participant said:

> I like this question that you are asking on prevention because our national office gives us a list of questions to answer for our 16 days of activism, and I have got an issue with that…because violence is here every day, and most of the time the work that we do is to deal with the effects thereof (response), not to combat (prevent) it as such.[750]

Other participants explained that the TCC does join in on prevention-related activities, which are run by NGOs such as Rape Crisis, or by the DSD, but that it is not essentially part of the integration project. Two of the four TCCs I studied, the ones in rural and peri-urban settings, had a more intentional practice of organizing community awareness campaigns, organized by the NPA supported personnel based at the centres

Contrary to the divided opinions on the TCCs prevention role, in Kenya, participants in all the four centres explained that prevention is a crucial part of the GBVRCs' role. Most participants described the GBVRCs prevention role in terms of community awareness activities and education that targets attitude change, as well as long-term empowerment and support to break the cycle of violence. Three of the four centres organised at least one community awareness session per month working with community health workers, paralegals and community activists. Social workers, or other designated service providers, would take the lead in organizing or coordinating community awareness campaigns and education activities. As one social worker explained:

> I am the lead person in community sensitization. We normally do a lot of school visits because we realize there is fear and they do no report. So, we do a lot of community sensitization. At least every month one school. We do community sensitization in churches because that is how you capture the caregivers and parents. We also go to

[750] Interview with victim assistant officer SA.D.4 on 17th November 2016.

> chief's *barazas* and any place that we get an opportunity, then we have to speak about sexual violence.[751]

However, the general sense in Kenya's GBVRCs, like South Africa's TCCs was that more could be done with proper budgets, capacity and resources. For instance, one participant explains:

> For community awareness, right now we do not go from the centre because of the shortage of staff. But in the past before we used to have a social worker who could go around with community health workers to conduct such community awareness activities.[752]

In both countries, the integration approaches clearly worked towards secondary prevention that is, intervening to provide critical support services to ensure the violence does not re-occur. Studies on service integration within the health sector have articulated the potential of integrated services in facilitating secondary prevention through early identification of cases where women are victims of violence, coupled with prompt referrals to support services to prevent re-victimization.[753]

6.5.1. Unclear Prevention Strategies and Lack of Institutional Accountability

In both GBVRCs and TCCs, the priorities, as revealed in resource investment and the institutions through which these resources are mobilized, influence the integration models more towards response, despite having prevention mandates or activity components. Kenya's GBVRCs, exhibit a more solid practice of contributing towards prevention through community engagement activities, facilitated by their linkages to community-resource structures and actors. The four GBVRCs were all established through institutions and partnerships that have mandates and concerns around strengthening health systems, including community engagement.[754] Accordingly, these integration centres showed a practice of working with

[751] Interview with social worker KE.B.5 on 7th June 2016.
[752] Interview with trauma counsellor KE.D.2 on 3rd February 2016.
[753] Garcia-Moreno. C., above note 132.
[754] For example see Project Implemented with Kenyatta National Hospital GBVRC by Pathfinder's USAID-supported APHIA II Nairobi accessed at https://apha.confex.com/apha/139am/webprogram/Paper246625.html on 15th May 2018; LVCT website accessed at http://lvcthealth.org/about-us/ on 15th May 2018; Nairobi women's GVRC, above note 554.

community resources in awareness and education campaigns to challenge attitudes that normalize sexual violence. However, since these activities were funded under periodic donor projects, the prevention-related activities remain sporadic, and are not being implemented as part of a sustainable strategy.

South Africa's TCCs approach, similarly, has no clear sustained strategy on prevention, despite having a prevention mandate in its blue print, reified by interview participants in this study. The TCC model deploys resources more towards response than prevention. It is not clear which stakeholder or sector within the TCC is accountable for resourcing the prevention component of the TCCs. Most participants said it is the DSD. However, a participant from DSD explained it is a shared role, saying, 'about prevention work, I also think prevention work is everybody's business it is not just a business of Department of Social Development. It is health, it is SAPS, it is NPA, as a government, as civil society, and we really need to look at that.' [755]

Therefore, in both counties, there is no clear strategy nor institutional responsibility for prevention-related activities of the integration models. There is a loose sense in which all sectors are responsible, with none taking actual responsibility, therefore accountability becomes difficult. In the context of limited resources and capacity, there is a need to clarify how and to what extent the integration models can realistically engage in prevention. Such conscious strategizing will allow for a method that streamlines and maximises efforts that are already being expended by the integration centres in this regard, especially on secondary prevention. In prevention, Kenya's Nairobi women's GVRC is an outlier in comparison to other centres from both countries. The centre has a clear prevention strategy and an entire program dedicated to prevention of sexual violence. [756] This example of having a prevention arm, or a point person for community engagement activities, is perhaps the most effective way of harnessing efforts towards prevention.

[755] Interview with key informant SA.KI.3 on 6th June 2017.

[756] Interview with program manager KE.A.8 on 27th January 2017.

To contribute towards the state obligation to prevent sexual violence, these integration centres would need to acknowledge in their strategies that response and prevention are not mutually exclusive categories. There is a need to coordinate resources and capacities that are already being used to conduct prevention-related activities. Since most centres are already engaging with communities in which they are situated, and allowing their statistics to identify sexual violence hot spots, which guide law enforcement strategies, there are opportunities and avenues for the centres to contribute towards prevention. In this way the victim of sexual violence will not enter the scene only after the violence, since the integration approaches will operate in a way that is conscious of potential victims in their jurisdiction.

6.6. Conclusion

This chapter has shown how the resources, mentalities, institutional structures and methods of the network players influences the orientations of the GBVRC and TCC integration approaches towards prioritising certain outcomes over others. This analysis of orientations is important because it allows us to reconsider how and why different structures, strategies and power forms influence the inclinations of integrated sexual violence interventions. By locating where victims are situated in the present orientations, the analysis provides an opportunity to conceptualize new ways of centring victims' needs and rights in sexual violence interventions.

The discussions show that South Africa's TCC model's service orientation is focused on improving criminal justice system outcomes, with diminished attention to comprehensive health care and psychosocial support. This orientation centres the sector mandates of the criminal justice agencies, with unequal involvement of the health and psychosocial service sectors. This orientation is designed to improve the experience of victims when reporting to the police, during investigation and prosecution. However, the model eclipses the long-term health and psychosocial needs of sexual violence victims. Therefore, while this orientation contributes to fulfilment of state obligations to prosecute and punish through criminal justice, it compromises the obligations to protect, prevent and provide adequate redress.

In converse, Kenya's GBVRCs are oriented towards comprehensive health care including long-term psychosocial support, which proves useful for health-related outcomes, however, there

is a significant disconnect with legal and justice sector responses. This orientation contributes to fulfilment of state obligations to protect and prevent through facilitating physical and mental health recovery including assisting women to break the cycle of violence. However, it compromises the obligation to prosecute and punish through holding perpetrators accountable.

Furthermore, there is a need to re-think how the integration models in both countries are contributing to the obligation to prevent through their community awareness and education activities. The lack of clear strategies to guide the prevention-related activities means that efforts being expended toward these activities remain sporadic. In addition, due to the lack of sustained strategies and institutional accountability in this regard, it is difficult to assess whether the prevention activities have any impact on challenging norms and attitudes, which are the root cause of sexual violence against women.

CHAPTER 7

SAFE HAVENS WITHIN FLAWED STRUCTURES: EFFECTS OF SYSTEMIC CHALLENGES ON INTEGRATED SEXUAL VIOLENCE INTERVENTIONS

7.1. Introduction

One impetus for integrating sexual violence interventions is to create safe spaces, where targeted and sometimes specialized, health, legal and psychosocial services for victims are provided holistically.[757] The findings here have shown that the integration approaches in both countries aim to create safe spaces of comfort for victims of sexual violence. These centres are located in designated spaces, separate physical structures within the health facilities that host them, to provide a conducive service environment for victims. Beyond being set-apart for safety in this physical sense, these multi-sector response models also seek to safeguard the processing of sexual violence cases by providing specialised services at hospitals, the police and even courts. It is this ideally 'protected', or low-risk environments created for servicing and processing sexual violence cases, that I refer to as 'safe havens'.

In this chapter I argue that although the integration models operate as safe havens; places of safety, comfort, dignity restoration, they are not removed from broader, mainstream, fundamentally flawed systems and structures in which they are embedded. This chapter takes a broader look at how the service orientations discussed in Chapter Six are themselves shaped by external factors and inequalities, that challenge these ideals of safe havens. The premise for this chapter is that state responsibility to exercise due diligence is also a systemic level responsibility.[758] Systemic due diligence is concerned with the responsibility to 'ensure a holistic and sustained model of prevention, protection, punishment and reparations for acts of violence against women and girls.'[759] This obligation requires the state to move beyond enacting laws and policies to implementing actions that aim to shift structural and systemic challenges, which are the cause and consequence of violence against women.[760]

[757] Keesbury, J. & Askew I., above note 45.
[758] Manjoo, R., UN Doc A/HRC/23/49/2013, above note 80.
[759] Ibid, para 20.
[760] Ibid.

This chapter shows that the integration models are embedded in social and economic systems that present challenges of resources, infrastructural and capacity gaps as well as retrogressive social norms/attitudes manifesting through common rape stereotypes. The safe havens are not removed from the limits, fallacies and assumptions of legal and institutional structures, especially regarding issues of evidence in prosecution of cases, punishment and provision of redress for sexual violence against women. Furthermore, these interventions are implemented within a geopolitical context of post-colonial, developing countries with funding dependencies that shape how service provision is structured.

The structure of this chapter is as follows: I begin by revisiting how the integration models create these safe havens for processing and servicing sexual violence cases, and what implications there are for state obligations. I show that the purpose for creating safe havens differs, depending on the orientation of the integration approach. I then discuss the flawed systems and structures that embed integrated service provision in both country contexts. I argue that to fulfil state obligations to prevent, protect, prosecute, punish and redress sexual violence against women, effects of flawed socio-economic, cultural, legal, institutional, and geopolitical systems and structures that embed the models need to be acknowledged and addressed. This can be addressed particularly by rethinking issues of discretion, formal and informal, as an important site of porosity through which systemic inequalities permeate the safe havens.

7.2. Integration Centres as Safe Havens: Creating Safe Spaces

State responsibility to exercise due diligence requires the implementation of multi-sector approaches that coordinate swift police, medical and social services in a way that ensures safety and security of sexual violence victims.[761] Hence effective multi-sector interventions respond to sexual violence as a crime and a violation of the victims' human rights through creating safe spaces and processes to address victim needs and fears of seeking redress.

As noted earlier, in both countries, through policy mandates and practice, the integration centres implement approaches that promote victim safety, security, respect, comfort,

[761] Abdul Aziz, Z. & Moussa, J., above note 47.

warmth and providing support within a trusting environment. In all the eight centres, I observed significant effort to create safe spaces, in a physical sense, with the centres having warm, comfortable, inviting spaces, secluded from mainstream service points and designated, to ensure privacy and confidentiality for victims. This also includes creation of child friendly environments and services, providing comfort packs and free services for sexual violence victims.

In both integration models, securing victim information was another way that integration centres aim to create safe havens. Participants across both country models noted the value of creating trust by maintaining privacy and confidentiality in handling victims and their information. In Kenya's GBVRCs this was ensured in ways such as, 'not using names, only numbers and so there is a lot of confidentiality',[762] or 'keeping victim files under lock and key to ensure they are safe,' [763]or 'as you can see we use confidential rooms to meet with survivors'. Another participant similarly said, 'we have the Witness Protection Act to prevent the victim from exposure to ensure the information that we are given are kept confidentially.'[764]

Similarly, South Africa's TCCs provided privacy and confidentiality through strict restrictions to the centres: 'we don't allow even other staff or anybody who doesn't belong here (TCC) to just enter this space because we need to protect our survivors'.[765] By co-locating services the TCCs also 'minimized the fact that she has to tell the story over and over'[766] reducing exposure to unnecessary ears. Some centres allocated a point person to be accountable for 'coordinating the victim information files to other providers, and keeps them safe under lock and key'[767] These safe havens contribute towards fulfilment of the state obligation to protect by avoiding public disclosure and stigma of sexual violence victims. The victims' need for

[762] Interview with social worker KE.B.5 on 7th June 2016.
[763] Interview with nurse KE.C.1 on 21st January 2016.
[764] Interview with police KE.C.4 on 21st January 2016.
[765] Interview with victim assistant officer SA.B.4 on 26th March 2017.
[766] Interview with site coordinator SA.D.6 on 14th November 2016.
[767] Interview with key informant SA.KI.2 on 16th November 2016.

privacy is essential in avoiding 'dangerous and humiliating harsh treatment in the reporting, investigation and prosecution processes.'[768]

7.3. Safe Havens through Protected Processes of Specialised Services

Safe havens are also created through protected processes, that is, using designated, specialised personnel, units or institutions to provide targeted health, legal and psychosocial services for sexual violence victims.[769] I call this 'protected processes' because the integration of specialised services at different points, such as hospital, police, shelter and courts, is to create a parallel stream of services for sexual violence cases, separate and designated from mainstream structures processes. Both the TCCs and GBVRCs seek to provide this parallel stream of services for sexual violence victims by integrating their services with other specialised interventions available in the respective country. To this end, linkages exist both at institutional and service provider levels for South Africa's TCCs and mainly at different service providers level for Kenya's GBVRCs.[770]

7.4. Safe Havens as Embedded Within Flawed Systems and Structures

Although these integration models seek to protect sexual violence victims, to facilitate prosecution, prevention (secondary), punishment and effective redress, they are influenced by broader, mainstream systems which pose challenges. These challenges compromise the fulfilment of these state obligations. In this section I discuss some of these flawed systems, and using findings from interviews, I demonstrate how they pose challenges which affect the safe haven ideals. I discuss these systemic flaws in three main parts, focusing on social, economic, legal and cultural flaws.

I begin the section by discussing effects of gender inequality, including patriarchy and the stereotypes it produces and intersecting socio-economic inequalities. Following this I

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[768] Abdul Aziz, Z. & Moussa, J., above note 47.

[769] Ibid. Abdul Aziz and Moussa suggest that such specialised response is more effectively because it creates user-friendly environment for victims. See also the UN Department of Economic and Social Affairs and Division for the Advancement of Women, *Handbook for Legislation on Violence against Women*, 2010.

[770] The Institutional specializations in sexual violence interventions are not unique to these country contexts. Morrison, Ellsberg and Bott's review of sexual violence interventions, in Africa, Latin America and the United States show that specialised processes increase access to justice. Morrison, A., Ellsberg, M. & Bott, S., above note 60.

highlight structural flaws in the legal system including legal constructions of evidence that still use stereotypes of 'real rape' to prosecute cases. Here, I hone in on systemic challenges, arising from medico-legal documentation discrimination perpetrated by Kenya's police surgeon. I also discuss limited conceptions of punishment and absent considerations of redress as part of structural legal flaws. In the last section I discuss the role of culture and religion in compromising the safe haven ideals.

7.4.1. Effects of Gender Inequality and Discrimination

a) Patriarchy and the Stereotypes It Produces

Feminist scholars argue that violence against women is rooted in unequal gendered power relations, which normalises, anticipates and justifies rape among other forms of sexual violence against women.[771] That sexual violence disproportionately affects women and girls,[772] is not only a function of increased exposure to individual or secondary risk factors such as witnessing violence in childhood, substance abuse or low education levels,[773] it is systemically rooted in gendered and other intersecting inequalities.[774] Sexuality is one means by which the culture of patriarchy maintains social control over women.[775] This system of inequality produces rape myths and stereotypes that excuse male sexual aggression while tolerating sexual violence, blaming, shaming and often questioning the veracity of the female victim's testimony.[776]

Regressive attitudes that tolerate sexual violence manifest in service delivery through stereotypical constructs that propagate myths which make certain rape victims believable (if rape-able), and others not. These myths accept certain experiences of rape as more credible

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[771] See for example Bennett, J., 'Circles and Circles: Notes on African Feminist debates around gender and violence in the 21 Century' (2010) 14 *Feminist Africa* 21; Gqola, P. D., *Rape: A South African Nightmare* (2015); Okech, A., 'Alternative discourses: A feminist approach to re-thinking security' 2011 *Women and Security Governance in Africa* 49.

[772] García-Moreno, C., Pallitto, C., above note 14; Yount, K.M., 'Worldwide prevalence of non-partner sexual violence' (2014) *383*.9929 *The Lancet* 1614; Stöckl, H., Devries, K., Rotstein, A. et al., 'The Global Prevalence of Intimate Partner Homicide: A Systematic Review', 2013 *The Lancet*, 859; Vetten, L., *Rape and Other Forms of Sexual Violence in South Africa: ISS Policy Brief* 2014.

[773] Krug, E., Dahlberg L.L., Mercy J.A. et al., above note 88.

[774] Mama, A.A., *Heroes and villains: conceptualising colonial and contemporary violence against women in Africa,* 1997.

[775] Cahill, A. J., above note 457.

[776] Artz, L. & Smythe, D. eds., *Should we consent? The politics of rape law reform in South Africa* (2008).

than others, therefore determining which experiences of sexual violence are deserving of the criminal justice systems response. A common descriptor, the 'real rape' myth, a term coined by Estrich[777] and expounded on by subsequent scholars,[778] refers to the 'typical' rape case often described as involving; rape by a stranger, involving injury, weapons were used, with evidence of physical resistance, to which the victim will report promptly. [779] This is as opposed to rape by an intimate partner, involving no injury, where no weapons are used, where there is no evidence of physical resistance and she does not report promptly.

Both Kenya's GBVRCs and South Africa's TCCs are not immune to the effects of these gender biases, stereotypes and discrimination practices which the system of patriarchy entrenches through institutional structures and the individuals that work in them. Despite efforts to create safe havens that integrate specialised services offered by trained health workers, counsellors, police officers, prosecutors, and social workers, among other frontline service agents, gender stereotypes were still discernible.

In both countries, these stereotypes were used to blame victims for the rape, implying that they somehow contributed to being raped. Other service providers' opinions were that women often make false allegations of rape after being caught in compromising situations. In Kenya, sexual violence victims gave several examples highlighting such stereotypes and gender bias. One victim noted that 'the first counsellor I dealt with asked me questions that were really uncomfortable… they suggested that I am the one who caused it (rape) to happen'.[780] In another centre, one victim similarly describes how she chose to drop the case after the police responded by accusing her of making a false allegation. She said:

> I expected that since she is a police woman she will be understanding, but the questions she asked me… (She sighs heavily) … how will we know it really happened?

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[777] Estrich, S., *Real rape* (1987).

[778] Shadle, B.L., 'Rape in the courts of Gusiiland, Kenya, 1940s–1960s' (2008) 51.2, *African Studies Review* 27; Artz, L. & Smythe, D., above note 44; Kelly, L., *Surviving sexual violence* 2013; Kelly, L. & Radford, J., 'Nothing really happened': the invalidation of women's experiences of sexual violence' (1990) 10 *Critical Social Policy* 39. Du Mont, J., Miller, K.L. & Myhr, T.L.., 'The role of "real rape" and "real victim" stereotypes in the police reporting practices of sexually assaulted women' 2003 *9*(4), *Violence against Women* 466; Spohn, C., & Holleran, D. 'Prosecuting sexual assault: A comparison of charging decisions in sexual assault cases involving strangers, acquaintances, and intimate partners' (2001) 18(3) *Justice Quarterly* 651.

[779] Smythe, D., above note 36.

[780] Group interview with sexual violence victims KE.A.9 on 28th January 2017.

> Maybe you are in cahoots with the doctor who wrote the medical report? To implicate someone?[781]

Yet another victim explains how the police mocked and shamed her once she reported. She said, 'even the police asked me, you 'how did you feel? Did you enjoy it'…stupid things?'[782] Similarly in a discussion with care givers of sexually violated children supported through one GBVRC, one mother explained that after her 16-year-old daughter who 'just has a woman's body'[783] was raped. The mother and daughter came to the GBVRC and they were referred to the police station gender desk. On arrival, the gender desk investigating officer said,

> '*Ah Ah nyinyi endeni huyu msichana wenyu ni mama*" (No way, you just go away, this daughter of yours is not a child, it is a woman) and they told me if I continued staying there they would take action against me.'[784]

These are examples of how gendered stereotypes were used to blame women for being raped, to discredit women as complainants who lie about rape and to mock women by suggesting that they enjoyed sex during rape. These perspectives, especially the last quote, shows how normalised and acceptable rape of women is, that the report of a child who looks like a woman is so easily discredited, because she is female.

Although I was not able to speak to victims in South Africa, similar stereotypes were nonetheless discernible from perspectives of some service providers. For instance, one case manager, a legal officer that screens the rape investigation case files before prosecution, explained that the type of rape case she would recommend for prosecution is where the victim reported promptly, and 'the complainant needs to have been sober and be able to identify their perpetrators'.[785] This participant went on to explain that, 'it is unfortunate at this time of the year because people go out to parties to be seen…etc.…etc., young girls hanging out at shebeens (illicit bars).' [786] The parameters that this case manager is using to

[781] Group interview with sexual violence victims KE.B.1 on 7th June 2016.
[782] Group interview with sexual violence victims KE.D.6 on 5th February 2016.
[783] Group interview with sexual violence victims KE.C.6 on 22nd January 2016.
[784] Ibid.
[785] Interview with case manager SA.B.4 on 24th March 2017.
[786] Ibid

decide if a rape case deserves to be forwarded to prosecution contain elements of the 'real rape' stereotype. These stereotypes are laden with assumptions that lead to some victims who go to illicit bars to drink as having contributed to the violation, which leads to interpretations that they are less deserving of criminal justice responses than other victims. In another TCC, one investigating officer linked to the TCC used this example to explain his challenge with rape cases:

> You see when parents are away from home and the boyfriend came through to the house and partying and they had sex together and everything. After a while, the mother heard from someone and then she (victim) comes in and says, "but he raped me."[787]

Similarly, a different investigating officer linked to another TCC also explained:

> Some of them have sex and there was no condom used, so they realise and say, "Oops, let's got to Thuthuzela". So, it is the tendency of she had sex and now you cry rape, but we must still attend to them.[788]

Such attitudes that discredit women as people who often lie about rape, as people who 'cry rape' for different reasons after being caught in compromising situations, have been problematized by feminist scholars.[789] Scholars have shown that rape and false allegations are more complex than is assumed.[790] In an analyses of several studies that try to prove or disprove whether women are likely to lie about rape or not, Smythe suggests that it is more useful to move beyond this binary to understand contexts in which false complaints arise.[791] Smythe's qualitative assessment of issues such as prior victimisation, third party reports, rape

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[787] Interview with police SA.D.7 on 14th November 2016.
[788] Interview with police officer SA.A.5 on 24th October 2016.
[789] Smythe argues that criminal justice systems the world over continue to be suspicious of women as rape victims. Women are often described 'as vengeful and vexatious trollops, bent on exacting revenge, or as good girls gone bad, regretful of needing to explain an inappropriate sexual liaison or unplanned pregnancy'. Smythe, D., above note 36 at 140, 160.
[790] Feminist activists continue to debunk the conception that women lie about being raped, a view which 'underpins evidence rules such as the cautionary rule, and the drawing of negative inferences from victims' late reporting.' Smythe, D., above 36 at 141; Munala, L., Welle, E., Hohenshell. E. et al., 'She Is NOT a Genuine Client': Exploring Health Practitioner's Mistrust of Rape Survivors in Nairobi, Kenya' (2018) 38.4 *International Quarterly of Community Health Education* 217; Parenzee, P., Artz, L. & Moult, K., *Monitoring the implementation of the Domestic Violence Act: First research report,* 2001.
[791] Smythe, D., above note 36.

of adolescents, sex workers and women with mental health problems, finds that 'false allegations occur in more complex contexts and are often informed by more diffuse motivations than simplistic or stereotypical accounts would suggest.'[792]

The problematic stereotypes and myths I describe here are present within the protected processes that the GBVRCs and TCCs service integration networks seek to establish. These are not accounts from general, mainstream service points, from which these specialised integration models seek to be separate. Manjoo argues that the state responsibility to exercise due diligence at a systemic level requires the implementation of measures aimed at 'concrete, overall societal transformation to address structural and systemic gender inequality and discrimination'.[793] Efforts to transform deeply rooted institutional and social norms should be holistic, targeting entire systems such as the police, judiciary, health systems and social welfare systems. If the systems within which the integration centres are embedded remain untransformed, the effects of systemic gender inequality and discrimination continue to permeate these safe havens.

b) Intersecting Socio-economic Inequalities

Not all women are vulnerable to sexual violence in the same way. Intersecting inequalities on the basis of race, class, gender, sexual orientation, disability converge in different ways to predispose certain categories of women to greater vulnerability for rape than others. Intersectionality allows us to unpack differences among and within these categories of women leading to more realistic conclusions of women's experiences of violence and the challenges they face in accessing support services after violence.[794]

Most women supported by the integration models were poor black women, living either in low-income settlements on the outskirts of urban centres or rural areas. Service providers also consistently mentioned that most of the victims were 'poor', with 'low literacy levels,'

[792] Ibid at 161.
[793] Manjoo, R., UN Doc A/HRC/23/49/ 2013, above note 80.
[794] Crenshaw, K., 'Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Colour' (1991) 43 *Stanford Law Review* 6.

'unemployed' or working in low-paying jobs in the informal sector. These socio-economic challenges affected women's access to health, legal and psychosocial services.

Therefore, a sexual violence victim presenting at the TCCs or GBVRCs was often experiencing the compounding effect of several other inequalities, making their needs multiple and complex. For example, in Kenya, one social worker explained that some victims could not come back to the centre or follow through with their cases because losing a few hours of work could mean losing their job as casual labourers. She said:

> Imagine some of them (victims) are working for example in these Indian shops as a casual worker, it becomes so hard for them to keep coming to the centre for counselling or to follow up the investigation… that's a challenge.[795]

Poor women especially in slums and rural areas face compounded challenges of accessing the TCC and GBVRC services, even if the state makes these services available. In another GBVRC, one participant explained that the lack of economic independence makes it difficult to break the cycle of violence hence the centre has 'started to include economic empowerment programs for women. We bring different partners to educate you and give you different options on how you can stand on yourself'.[796] This participant explained that they do this because, 'you know from our statistics, most of our survivors are coming from poor economic areas that tells you that they are not literate, so we educate them about the laws.'[797]

Therefore, the experiences of women seeking services at the GBVRC centres were compounded by socio-economic challenges over and above the known difficulties of reporting rape. As shown above, one of the four GBVRCs has adapted its program to respond to these needs of illiteracy and poverty, through including victim education programs and linkages to economic empowerment programs.

In South Africa's TCCs participants raised similar challenges of poverty, social insecurity, especially because of living in areas with gangster activity, drugs and organised crime. For example, one counsellor describes the fear and challenge of providing counselling services

[795] Interview with social worker KE.D.1 on 3rd February 2016.
[796] Interview with program manager KE.A.2 on 2nd February 2017.
[797] Ibid.

within a semi-permanent structure right opposite a complex of flats known for gang-related crime, where it was not uncommon to hear gun shots at night. She said:

> You see we are all here near opposite the road, there is lots of gang violence on here, and sometimes we work in the evening and we hear the gunshots. So, yes to me the TCC is actually on a very fragile place because if that bullet comes through here and you are busy with the victim, what are you going to do? Because this building (TCC) is not made of bricks, so the bullet comes right through here.[798]

This participant also gave examples of how victims opted not to prosecute or receive other TCC services because sometimes the perpetrators are known gangsters who 'threaten her life, her family members, causing harm to the victim because she now doesn't know what to do because she fears for her safety. So, some of them just stay away because of these reasons.'[799]

These experiences show that systemic socio-economic inequalities such as poverty, insecurity, lack of education affect how effective and accessible integrated services are to all women victims. As a result, the safe haven ideals of the TCCs and GBVRCs are compromised by challenges of access to the services, lack of victim safety once they leave the centre, and lack of economic independence, keeping victims in a cycle of violence.

The systemic level state responsibility to act with due diligence requires that states not only have the formal existence of mechanisms to provide needed services and remedies, but that they are made effective and available to all women.[800] The question to consider here is whether integration models acknowledge this complexity of context in which women victims' experience violence, in designing service delivery models to support them. The examples given above of integrating legal education programs and linkages to economic empowerment programs is one way in which one GBVRC in Kenya is responding to this complexity of victim's needs. GBVRCs in rural and peri-urban settings had no similar strategies due to resource challenges. None of South Africa's TCCs included linkages to victim education or economic

[798] Interview with counsellor SA.D.1 on 16th November 2016.
[799] Ibid.
[800] *Jessica Lenahan v United States* Case 12.626, Report No. 80/11 (2011), OEA/Ser.L/V/II.142 (2011).

empowerment interventions. The failure by the states to target holistic, social-economic transformation compromises women's substantive access to justice and other services, even when they are made (formally) available through the creation of such integration centres.

7.5. Legal and Institutional Systems: Limits, Fallacies and Assumptions

Both Kenya and South Africa have progressive legal and policy frameworks enshrining protections for women who are sexually violated, as discussed earlier. In terms of evidentiary procedures both laws strike out the requirement for corroboration, limit the contexts in which evidence of previous sexual history can be adduced, and include victim protection measures such as intermediaries to facilitate testimonies of vulnerable witnesses.[801] The implementation of these laws through the service integration centres reveals some challenges in practice arising from how frontline implementers understand the role of legal systems and what they can accomplish. In this section I give examples of how the limits of the law, as well as fallacies and assumptions of service providers in practice, affect the safe haven ideals of the integration models as they seek to support victims of sexual violence.

7.5.1. Legal Constructions of Evidence: Persisting Preference for Slam-Dunk Cases

The holistic response of multi-sector collaboration approaches is expected to facilitate improved evidentiary procedures in rape cases. Integrating the services of specialised or trained health care providers, police, prosecutors and courts, create safe havens which are expected to ensure the legal reforms in the area of evidence are implemented in the processing of sexual offences. However, there are systemic and structural challenges that affect how the police and prosecutors decide what evidence is good enough to allow sexual offence cases to remain in the criminal justice system.

South Africa's TCCs are embedded within South Africa's National Prosecuting Authority where prosecutors are generally appraised based on their conviction rates.[802] The challenge with this

[801] Kenya Sexual Offences Act; South Africa Criminal Law (Sexual Offences and Related Matters) Amendment Act.

[802] Schonteich, M., 'Strengthening prosecutorial accountability in South Africa' (2014) 255 *Institute for Security Studies Papers* 24.

statistics-driven approach is that it leads to cases being 'selected for success',[803] meaning that only having what is deemed as 'obvious' evidence will be prosecuted. One participant, explained:

> Prosecutors are under a lot of pressure because the NPA are statistics-driven. The prosecutors' performance is evaluated is based on their conviction rates, and you know that the best way to get a high conviction rate is to take a slum-dunk case to court, and the problem with rape cases is that they are very difficult to prove.[804]

With conviction rates as the way of measuring success, 'slum-dunk' cases, such as those that are reported promptly, with forensic DNA evidence, or physical evidence of injury become appealing to prosecutors. This way of measuring success not only validates the 'real rape' stereotype as discussed earlier, it violates the rights of victims to access justice. It compromises fulfilment of the state obligations to prosecute, punish and provide redress to sexual violence victims. In Kenya, some victims explained how they were turned away from reporting because their cases lacked obvious evidence, that is forensic evidence. One participant explains her reporting experience:

> With me I tried to report, I went to police station, I was not really helped, especially when the police saw that the hospitals report shows I had taken a bath, it was marked with a tick, they said oh if you bathed as we can see, then we cannot help you.[805]

The insistence on having additional evidence, especially DNA evidence, injury or additional witnesses for sexual violence cases to be deserving of investigation or prosecution was common practice in both countries. Criminal justice agents continue to seek corroboration in practice, despite evidentiary law reforms that removed this requirement. It is a fallacy so deeply entrenched in the criminal justice system that it passes for being a practical or pragmatic reality in the selection of cases that should remain in the criminal justice system.[806]

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[803] Ibid.

[804] Interview with key informant SA.KI.4 on 12th April 2017.

[805] Group interview with sexual violence victims KE.B.1 on 7th June 2016.

[806] Feminist perspectives on evidence challenge the use of such narrowly defined categories of evidence and argues that truth in sexual offences matters, as in other matters, is best achieved through wide scoped fact-finding processes that allow the input of victims' voices. Nicolson, D., 'Gender, Epistemology and Ethics: Feminist Perspectives on Evidence' in Childs, M. & Ellison, L. eds., *Feminist perspectives on Evidence* (2000) 32.

Reliance on such fallacies and assumptions affects the safe havens created by integration models. Since the centres seek to facilitate sensitivity and understanding of sexual violence context, training and specialised responses should facilitate the progress of the more 'difficult' sexual offence cases in the criminal justice system. This is because a specialised understanding of the nature of sexual offences should lead service providers to present evidence that explains why facts which might otherwise be interpreted in a negative way, should be construed in the social context in which these offences occur. For example, specialised responses should explain why women delay reporting rape cases, rather than drawing a negative inference from such a fact.

7.5.2. The Police Doctor Conundrum: A Legal (Practice) Fallacy

An enduring practice in processing rape cases is the requirement that the P3 form, should be filled in by a police surgeon, commonly referred to as the police doctor. For the longest time, there was only one police surgeon servicing Nairobi, Dr. Kamau.[807] The common understanding in practice is that all victims of violent crime, not just sexual violence, are expected to queue at Dr Kamau's office, for hours or days on end, until their P3 forms are filled in. Women's rights activists and advocacy groups have consistently lamented this concern, calling for more police surgeon's to be employed.[808] Findings of this study show that there are 'now three police surgeons in the country, working under the ministry of health, forensic and pathology service and the National police service based at the traffic headquarters in Nairobi.'[809] The fallacy here is that only the police doctor can fill in the medico-legal P3 form. This is contrary to practice guidelines which prescribe that sexual violence survivors should be treated free of charge at public health facilities and also make it mandatory for 'a "designated person" who examines survivors of sexual violence to fill in both the PRC and P3 forms. The designated person can either be an enrolled or registered nurse, registered clinical officer or medical doctor as defined by their respective registrations acts.[810]

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[807] Munene, K., 'The long but eventful wait for a P3 form' *Voice of Africa* 5th July 2018.
[808] Matata, L., 'Kenya: Rape and the Elusive P3 Form' *All Africa press* 18th December 2013; Nekura. R., above note 35.
[809] Interview with key Informant KE.KI.1 on 3rd February 2017.
[810] Kenya Sexual Violence National Guidelines, above note 4.

This provision allows registered doctors, nurses or clinical officers to fill in the medico-legal forms. However, several service providers explained in the interviews that they still send all victims only to the police surgeon for the P3 form to be filled in. Victim's experiences at the police surgeon were filled with traumatising details of delays and secondary victimization in the process of getting this medico-legal form filled in. For example, one victim said:

> I was told to arrive at the police surgeon's by 5:00am because of the long queues. So, when I arrived I was already number 70 something in the queue. I told the person who was in charge there that I cannot stay any longer… He told me, just give me 2000Ksh and I will give your form over to the doctor. I gave him. The next day over lunch break I was back to the police surgeon. He told me I can just give him that 5000ksh for tea. I sent it to him through Mpesa (mobile money). He then wrote a lot of things on the paper and told me to go back to Kilimani police station.[811]

This victims experience exemplifies challenges such as delays, unnecessary threats that the evidence needs to be coaxed, corruption and bribes. Service providers referred victims to the police surgeon despite knowing what the guidelines state, as one participant explained:

> Yes, the thing (treatment regulations/guidelines) says there at the bottom; the clinical officer, medical officer and nurse can fill it, but it is not really being followed, because courts are under the impression that government is un-corruptible, so they think if you go to a private doctor you can maybe fill whatever you want.[812]

Similarly, another participant explained that only the police surgeon can fill in the forms because 'the government needs to use its own people, otherwise how will they know that this person was not compromised. They use their own resources, it is mandatory.'[813] Therefore, the main reason why rape victims in Nairobi have to rely on the police surgeon to fill in P3 forms is that courts will accept evidence from a government doctor rather than a private doctor. Even if this is the case, the police surgeon is not the only registered government doctor.

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[811] Group Interview with sexual violence victims KE.B.1 on 7th June 2016.
[812] Interview with case manager KE.A.6 on 2nd February 2017.
[813] Interview with key informant KE.KI.1 on 3rd February 2017.

Further showing the absurdity of this practice, there are no police surgeons in any other part of the country other than Nairobi, yet rape cases continue to be prosecuted in these jurisdictions. The two other integration models I studied here, in the peri-urban (Nakuru) and rural (Kitale) settings made no mention of such a practice. P3 forms were filled in by designated clinical officers or doctors within the health facilities. The safe haven ideals of integration centres in Nairobi were greatly compromised by victims being expected to bear this burden of having the most crucial documentary evidence signed off only by police surgeons. The same police surgeons who are also responsible for examining all kinds of cases including 'other violent crimes, road accidents, occupational hazards and animal attacks.' [814]

The persistence of this system of using police surgeons causes significant difficulties for victims in the process of reporting rape cases, compromising the state obligation to protect, prosecute, punish and provide adequate redress. Systemic level state responsibility to exercise due diligence in addressing sexual violence requires that the state's efforts should train and capacitate service providers and institutional structures to ensure compliance with laws and practice guidelines.

7.5.3. Limited Conceptions of Punishment

One of the measures under the due diligence framework for state accountability for the prevention of violence against women is that a state should enshrine broad conceptualisations of punishment.[815] From a victim-centred perspective, the idea here is that narrowly conceptualised punishment regimes that only focus on the perpetrator and the state as prosecutor are likely to periphery the person to whom direct harm was occasioned, the victim.[816] Broad conceptualisations call for the need to think beyond the criminal justice system, to include civil, administrative and other penalties with the overall aim being to ensure negative consequences for the perpetrator for committing the offence. Beyond deterrence and retribution, a comprehensive approach to punishment pays regard to

[814] Ibid.
[815] Abdul Aziz, Z. & Moussa, J., above note 47. Haylock, L., Cornelius, R., Malunga, A. et al., 'Shifting negative social norms rooted in unequal gender and power relationships to prevent violence against women and girls.' 2016 *24*(2), *Gender & Development* 231.
[816] Spies, A., above note 483.

rehabilitation and restorative justice, which acknowledges systemic intersecting inequalities.[817]

Since the integration models are a critical point of contact for victims to receive support, get advice and to disclose their wishes, I wanted to find out what punishment options are available to victims. In both countries, while several tangents of responses arose in both country contexts, there were stark similarities in the narratives that reveal the many limits of the legal system, which negatively affects the safe haven ideals of the integration models.

First, it was clear that criminal justice was seen as the only legal recourse that victims were allowed, if not vehemently encouraged to pursue. Sexual violence victims were encouraged to pursue criminal justice to ensure the safety of other people in society. One counsellor explains:

> For me I think they take it up (prosecution process) because we ask them if you remain silent this thing will continue, no one will know that people are being raped. Especially when people travel they arrive at night and they are raped.[818]

This greater good perspective centres issues of punishment on deterrence. While important, this approach places an undue burden on victims to protect other women from being raped, which diminishes or de-centres the punishment question, for the specific victim. With criminal justice as the default and often only avenue to justice, victims have no real options within this rigid legal framework, as one participant explained:

> Don't you think the criminal justice system imposes the options onto victims- because the criminal justice system objectives is the finalization of the case, whether it is through conviction or acquittal, so that is the framework within which a victim must fit, so when we are saying the approach is victim centred, is it really victim centred from a punishment perspective?[819]

[817] Wood, J., Shearing, C. & Froestad, J., above note 301.
[818] Interview with counsellor KE.D.2 on 3rd February 2016.
[819] Interview with key informant SA.KI.4 on 12th April 2017.

In both countries, when I asked what other avenues for punishment the service providers discussed with victims, most participants were perplexed or got uncomfortable, before often reiterating the narrative that any other alternative to criminal justice was counter-justice. The police, prosecutors and legal aid officers often said they do not discuss other options with victims because they do the victims simply do not understand the law. For example, one TCC case manager participant said:

> Well we don't have survivors asking because they usually don't know the law, but what we do we get the Victim impact report from the DSD who then sends out a Social worker to the complainant and immediate family.[820]

The Victim Impact Statement was identified as the only avenue through which a victim's voice enters the system, other than being a prosecution witness. One participant explained that while this is the only avenue for victim engagement, it came late in the process and often as an afterthought. She said:

> I would love the victim impact report not to be an afterthought, it should be the first thing that any Prosecutor thinks of because …I have worked with so many victims that they felt the court process was so clinical, feeling they were treated as a number, a case docket, not as a victim.[821]

Another limitation is that any other punishment arising out of a civil or administrative remedy would require the victim to file a civil suit only after the criminal matter is finalised, and upon conviction. This raises challenges of legal costs and delays which victims would have to bear in addition to the tedious criminal matter. In both countries, none of these alternatives to criminal justice had been recommended or pursued in any of the eight integration centres.

With the assumptions that conviction is the ultimate form of justice, any other punishment considerations, or questions were quickly refuted as being counter-justice. They were all lumped into one category of 'out- of - court settlements', described as being dangerous, due to their informal nature. While acknowledging potential inequalities that can exist in

[820] Interview with case manager SA.A.4 on 24th October 2016.
[821] Interview with key informant SA.KI.3 on 6th June 2017.

unregulated informal justice systems, limited considerations of punishment that only consider criminal justice compromises fulfilment of state obligations to punish and provide adequate redress to sexual violence victims.[822] To fulfil their due diligence responsibility, states should develop mechanisms that encourage courts to impose other punishments in addition to or perhaps instead of imprisonment, as long as the victim's safety can be guaranteed.[823] The sole focus on the formal justice system, which does not involve restorative components, may seem unfamiliar especially to poor rural communities who have no access to these systems.[824]

7.5.4. Absent Considerations for Adequate Redress

If punishment is about what happens to the perpetrator, redress is about what happens to the victim.[825] Therefore, these two themes intersect. State obligations to provide adequate redress for sexual violence is fulfilled when the state avails adequate remedy or compensation to victims for harm suffered. While punishing the perpetrator forms part of redress, it also encompasses monetary compensation, apology or other symbolic reparations. As a transformative tool, reparations have the potential to address the root causes of violence. [826]

Following from discussions above, it is unsurprising that there were absent considerations in terms of redress or reparations for victims of sexual violence. Conviction and imprisonment were not only assumed to be the central meaning of justice, but the only possible way to recognise a victim's harm. Accordingly, a victim's harm and suffering could only be further redressed as additional, aggravating factors, to get tougher sentences for perpetrators.

For example, when I asked one participant about what forms of redress or remedy the victims who came to the TCCs could access, she said:

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[822] Manjoo, R., above note 70.
[823] Koss, M.P., 'Blame, shame, and community: justice responses to violence against women' (2000) 55.11 American *psychologist* 1332.
[824] Moult, K., *Justice served? Exploring informal justice mechanisms dealing with violence against women,* 2003.
[825]Abdul Aziz, Z. & Moussa, J., *Due-Diligence Framework; State Accountability Framework for Eliminating Violence against Women*, Regional report: Africa, 2014.
[826] McGlynn, C., above note 485 at 826.

> Prosecutors only argue for direct imprisonment, so in terms of compensation, where will the money come from? So, we don't really follow the compensation route, because we use those factors as aggravating factors for a higher sentence. We substantiate to the court why for instance the court should impose 20 years instead of 15 because that shows the impact of the incident on the complainant and the family. So, we don't follow that avenue.[827]

In both countries, the question of redress, reparations, much like questions on broad considerations for punishment, were met with uncomfortable and mixed reactions from service providers. Participants often questioned why a victim would want anything other than imprisonment of the perpetrator, branding those who do as either ignorant, uncooperative or counter-justice. The goal then, as explained, was to educate victims about the nature of the system. One police officer supporting a GBVRC stated:

> The thing you can do is to enlighten them on the Kenyan criminal justice system and the process that is followed, that the end finding is punishment and not payment. So, they have to be enlightened that we are following this case to punish the accused not for financial gain, so that even if it happens, they have to know one; the procedure, and two the expected outcome. So that they don't have this expectation in mind, that I can be paid.[828]

Like this police officer, several participants described compensation as a form of pay-off. They largely conceptualised compensation as part of illegal negotiation processes, happening within unregulated cultural practices that seek to diminish the rights of victims by justifying violence against women. Compensation and any other forms of redress were often pitted against minimum sentencing legislation, as the only ultimate and just legal response, which is predetermined and rigid, leaving no room for other considerations of redress. For example, to the question: 'how do centres facilitate victims in seeking redress?' one manager at the Nairobi Women's GVRC said:

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[827] Interview with case manager SA.A.4 on 24th October 2016.
[828] Interview with police officer KE.B.6 on 6th June 2016.

> That is not within me. This is well put within the Sexual Offence Act. The punishment is well defined, year by year, what kind of punishment. That is where our partners in the legal field come in to educate the survivors.[829]

The legal systems understanding of victim reparations, at best, is in the form of stringent sentencing regimes. This shows how little regard is given to the victims of criminal injustice. Those who understood the reparative value of compensation raised legal challenges around how enforceable it could be. They also raised practical challenges such as who would be responsible for paying such compensation if perpetrators are poor, or in jail. One social worker suggested that where perpetrators could not pay, the state could take responsibility by paying victims out of the fines that suspects pay for bail. She said:

> I would find the survivors loosing. If I was asked, I would recommend that the money the perpetrator pays if he is fined, that part of it should go to the survivor, especially children. Their inner parts are destroyed, and you never know how they are going to function later. You know there is the physical and emotional pain.[830]

Feminist and victim's rights advocates continue to argue against the culture of criminal justice that limits the recognition of a victim's harm to a prison sentence.[831] It is important that sexual violence is criminalised and addressed as such. However, the legal system is flawed if a victim's best hope at redress is that the perpetrator will be imprisoned. This way of thinking focuses on what happens to the perpetrator and pays no regard to what should happen to the victim to ensure reparations and remedy. Since not enough thought, or research has gone into what alternatives for adequate redress look like, one participant suggested that one way to foster debate is to start by ensuring victims are heard. She explained:

> Why our victims walk away more hurt from the justice system is because they were not heard. So, if we create more platforms and move away from just getting a case away from the court roll, you know, so if you move away from that, and take time and

[829] Interview with program manager KE.A.2 on 2nd February 2017.
[830] Interview with social worker KE.B.5 on 8th June 2016.
[831] Spies, A., 'Substantive equality, restorative justice and the sentencing of rape offenders' (2016) 3 *SACJ* 273.

> listen to what happened, yes it might be two minutes, five minutes, but it can change that person for the rest of their life.[832]

Another missed opportunity for ensuring victims' access to adequate redress is in facilitating victims' participation in the process of parole hearings, for the release of the perpetrator. Of all the eight centres in both countries, only one TCC involved correctional services as part of their collaboration networks to ensure victims are informed of and they participate in parole hearings, if they wish to. One participant from this TCC explained:

> We link up with the Parole Board and we complete a form on behalf of each victim indicating that she wants to be contacted, should the suspect be eligible for parole. Because you know what, if it is a family member then she just sees him one day, and he just rocks up you know, it is very traumatic for victims. So, the Parole Board knows that they cannot just release the suspect without the victim having inputs in the process.[833]

For the other three TCCs, most service providers considered their role discharged upon conviction, as one participant said, 'It may be terrible to say this, but our job basically comes to the end when the suspect is convicted. Now we need to focus on getting the rest that we have to jail.'[834]

Therefore, other avenues of involving victims in criminal justice, such as in the process of parole and release of the perpetrator were absent. For the GBVRCs, the weak linkages to the justice system meant there was even less consideration for partnerships with regard to linking victims to correctional services. One of the three centres said that they have a loose partnership with the parole board because they 'are usually part of the team we have in the court users committee'[835] however, they do not work with them. This section has shown that in both country integration models there was very limited considerations for reparations and redress for sexual violence.

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[832] Interview with key informant SA.KI.3 on 6th June 2017.
[833] Interview with case manager SA.C.3 on 15th March 2017.
[834] Interview with key informant SA.KI.2 on 16th November 2016.
[835] Interview with nurse KE.C.1 on 21st January 2016.

7.6. The Role of Religious and Cultural Systems and Structures

In both countries, community and faith-based organisations formed part of the critical referral partners, as an important place of refuge for victims, especially in terms of follow-up care and support. For example, religious leaders were among the trusted people to whom victims and parents of victims disclosed the sexual violence experience; as one participant said, 'I did not tell anyone, but I told the pastor that there are things that happened to me'.[836] This theme came up in all interviews with victims in Kenya's GBVRC. Some victims also spoke of how they decided to forgive the perpetrators and leave it to God to move on, as one victim noted: 'Since we are Christians you know, if you even suspect somebody you cannot say it is them, because you did not see them, so we had to stand on forgiveness, then we just left it.'[837]

In South Africa's TCC, service providers often mentioned that faith-based organisations were an important point of support for victims. For example, one counsellor explains:

> Remember churches have also support group for women in the community, where they are holding maybe every Tuesday they are holding a prayer or devotion. I usually ask survivors "Is there such a support group for you in the community? Is there a person you can trust? Like a pastor?" That is also part of support.[838]

Therefore, religious structures and faith-based organisations were used as a form of continued support, either because of the legitimacy they hold as structures or as the only available means of support in resource-constrained settings. Research on the use of informal justice systems to address violence against women in South Africa shows that they can 'alleviate some of the immediate problems faced by women in seeking services' such as costs of travel for services and language barriers.[839] In addition, such informal mechanisms are often preferred because they create an opportunity for victims to be heard, their proceedings are familiar and such community structures are accepted as legitimate.[840]

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[836] Group Interview with sexual violence victims KE.D.6 on 5th February 2016.
[837] Ibid.
[838] Interview with lead counsellor SA.D.2 on 17th November 2016.
[839] Moult, K., 'Providing a sense of justice: Informal mechanisms for dealing with domestic violence' 2006 *South African Crime Quarterly*, 12.
[840] Ibid.

However, such informal mechanisms can be avenues through which cultural and religious structures propagate inequality, and diminish sexual violence victims' needs, rights and interests.[841] As critical parts of social organizing, such structures are also sites where patriarchal attitudes and subsequent stereotypes can fester and be reproduced, with the extra dangerous layer that they carry a level of legitimacy and trust in the communities.[842]

In both countries, religion and culture were raised as a challenge that was used to justify illegal, out-of-court settlements, preventing women from continued access to support services. For example, one GBVRC counsellor noted that, 'as they (victims) push for justice on this side, other relatives' judge and try to stop, then culture comes in as well as religion to try and stop one from getting justice.' [843] Similarly, one TCC site coordinator noted that people from some communities use culture to encourage out-of-court settlement for rape cases, saying:

> Normally in the Xhosa cultures where they usually they will talk things out first before they will decide, in terms of the Xhosa religion where they usually say that we are not going to open a case now.[844]

These experiences show that culture and religion form part of the social context within which the GBVRCs and TCCs are operating. While acknowledging the relevance of cultural and religious structures, they can be ill equipped to address sexual violence, or worse impede access to justice. Part of a state's obligation of due diligence at the systemic level is to implement mechanisms that challenge systems of cultural and religious inequalities that propagate gender inequality.[845] A failure to address such inequality compromises the safe

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[841] Tavrow, P., Withers, M., Obbuyi, A. et al., above note 1734; Kagwanja, P.M., 'Ethnicity, gender and violence in Kenya' (2000) 9 *Forced Migration Review* 22; Jewkes, R. & Abrahams, N., 'The epidemiology of rape and sexual coercion in South Africa: an overview' (2002) 55 *Social Science & Medicine*; Moffett, H., 'These women, they force us to rape them': Rape as narrative of social control in post-apartheid South Africa' (2006) 32.1 *Journal of Southern African Studies* 129.

[842] Ibid.

[843] Interview with counsellor KE.A.1 on 31st January 2017

[844] Interview with nurse SA.B.3 on 26th March 2017.

[845] Manjoo, R., above note 80, para 15.

haven ideals of service integration centres and compromises victims' right to protection, prosecution, punishment as well as access to effective remedies for sexual violence.

7.7. Discretion as a Site of Porosity

The sections above have discussed how social, economic, cultural, religious and legal systemic and structural flaws within which the integration models are embedded, and how they can compromise the safe haven ideals of service integration. This next section argues that one of the ways in which the structural and systemic flaws permeate into the safe havens is through discretion, as exercised by service providers. While discretion was not a central question in my research, the analysis shows that the decisions of service providers act as sites of porosity, where some of the systemic flaws discussed above permeate into the safe havens. Below I discuss how case managers, health workers, police officers and counsellors, exercised discretion, formal or informal, in ways that reflect these systemic inequalities, compromising the safe haven ideals of the integration models. [846]

Since South Africa's integration approach is oriented towards improving criminal justice system outcomes, the use of prosecutorial discretion was more apparent, especially through the office of case managers. Case managers are legal officers, mostly former prosecutors, appointed by the NPA, to support TCC cases.[847] While they do not directly prosecute, they lead the prosecutor-guided investigations for rape cases through preparing the dockets, instructing detectives on legal issues pertaining to the case, with the aim of strengthening the quality of the cases. [848] When discharging their duties, i.e. screening the dockets, and consulting with victims to review the veracity of their statements, they make decisions as to whether the case will proceed or not.

Case managers are peculiar because while they are not prosecutors, they perform prosecutorial duties in relation to TCC cases. The advantage of this role is that it gives the TCC

[846] Moult argues that the exercise of discretion by front line service providers is not only constrained by 'formal rules such as laws, but by social, economic, political and practical constraints' Moult, K., *Gatekeepers or rights keepers? Domestic violence court clerks and the administration of justice in South Africa* (Doctor of Philosophy in Justice Law and Society thesis submitted to American University, 2010) at 13.
[847] Interview with key informant SA.KI.4 on 12th April 2017.
[848] Artz, L., Smythe, D. & Leggett, T., above note 50.

cases a fresh set of legal eyes. Accordingly, gaps in the investigation process can be identified early on, and addressed to increase the prospects of success. However, if their discretion is not exercised with the sensitivity required, this pre-prosecution process becomes detrimental because it is an extra hurdle that rape cases have to overcome, to be proved worthy of prosecution. A hurdle that is dangerous and unnecessary because it does not exist in other criminal matters.

The dangers of *nolle prosequi*: the discretion to stop criminal proceedings, exercised by prosecutors has been debated at length in common law jurisdictions,[849] often because there are limited guidelines as to how prosecutors make such decisions.[850] The formal determinant factor in such decisions is that the criminal justice system expects that cases will be proven beyond reasonable doubt, as stated by one case manager: 'Our directive from the National Prosecuting Authority says that if there are no reasonable prospects of success we cannot take a matter to court'.[851]

'Reasonable prospects of successes' can be interpreted differently, with possibilities of being informed by both professional and personal value judgements. Studies on rape attrition, and management of rape cases in criminal justice systems have highlighted how rape stereotypes can be applied to exclude some cases from being prosecuted.[852] This chapter has already shown how some case managers expressed stereotypes and myths that place blame on and shame women for being raped. We have seen examples where participants thought that rape victims place themselves in risky situations, hence "they called for it", and the system should not be blamed for being unsympathetic.

Beyond these stereotypes however, other systemic flaws affected how case managers exercised their discretion. For instance, since the prosecutorial system is evaluated based on conviction rate targets, it was clear that some decisions were made based on what Schonteich

[849] Schonteich, M., above note 802; Emery, L.A., 'The Nolle Prosequi in Criminal Cases' (1912) 6 *Me. L. Rev* 199. Mwalili, J.J., *The role and function of prosecution in criminal justice* (1997).
[850] Schonteich, M., above note 802.
[851] Interview with case manager SA.A.4 on 24th October 2016.
[852] Artz, L. & Smythe, D., above note 38.

calls 'selecting for success', which means the more difficult or hard to prove cases were not pursued.[853] One case manager explains:

> We screen the docket to determine whether or not we have sufficient evidence to institute prosecution. It is unfortunate that a number of those cases the suspects are unknown and unidentified, and those cases can't be taken to court.[854]

The fact that a suspect is unknown and unidentified was raised by several participants as a major hindrance to investigation. However, the 'no suspect, therefore, no case narrative', which comes up in decisions of police officers as well, both in Kenya and South Africa, seems summary, and was often not qualified by explanations of how efforts to identify suspects had failed. That a suspect is unknown to the victim or unidentified would seem to be the precise purpose of an investigation process rather than a reason for dismissing a case.[855]

As described earlier, most sexual violence cases are hard to prosecute. Statistics-driven prosecutorial systems cause case managers to exercise discretion in a way that considers not only how they (being trained) might understand the evidence of rape, but how others in the criminal justice system (being untrained) will receive this evidence.[856] For example, one case manager's response to how they make the critical decision to prosecute or not was that it also depends on how other legal officers, like magistrates, or the defence counsel are likely to receive that evidence. She said,

> I decide based on the evidence. You know we have to prove our cases beyond reasonable doubt. Being prosecutors, it comes from experience, knowing that this is what the defendant will argue, and this is what the magistrate will decide, or more or less and then you make your decision.[857]

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[853] Schonteich, M., above note 802.
[854] Interview with case manager SA.C.3 on 15th March 2017.
[855] The African Commission has found that the lack of sufficient information concerning suspects is an excuse that should not stand in the way of effective investigations because it compromises fulfilment of state responsibility to exercise due diligence in prosecution and punishment of perpetrators. *Egyptian Initiative for Personal Rights and INTERIGHTS v Egypt* Communication No. 323/06, 12th December 2011, African Commission on Human and Peoples' Rights.
[856] The training I refer to here is the sensitivity training, on how to handle sexual violence cases, not legal training.
[857] Interview with case manager SA.A.4 on 24th October 2016.

Therefore, cases with no 'obvious' evidence, with evidence that magistrates are likely to reject, or evidence that the defence can easily argue away are less likely to be supported through prosecution. Thus, while case managers are expected to provide specialised protection and safety in the processing of cases coming into the integration models, they may in practice do the opposite. If their discretion is exercised in a way that brings specialised and gendered sensitivity to the complex nature of rape, it can be useful in giving the necessary explanations to court that will counter negative inferences drawn from rape stereotypes that commonly plague prosecutions. However, if their discretion is exercised in a way that pays regard to statistics-driven systems of appraisal or patriarchal systems that reproduce rape stereotypes, then it affects the safe havens model that the TCC seeks to establish for these cases.

While mostly discernible with South Africa's case managers, issues of discretion were not limited to them. The section on gender inequality above has shown how police officers and counsellors made decisions and were influenced by gender stereotypes that blamed, shamed and mocked women victims, causing secondary victimisation even within the GBVRC and TCCs protected processes. In Kenya, some health workers also took decisions not to call the police to the centre for investigation, or not to refer cases to the police if they did not think there was sufficient 'obvious' evidence for successful prosecution. For instance, where the victims did not know the perpetrator or where there was no forensic evidence. One victim explained what a health worker at one GBVRC told her. She said: 'For me I went to the hospital first, then since I did not know who those people were (perpetrators), I was not sent to the police.'[858]

Health workers and counsellors also stated that with limited evidence, and given the resource challenges, referring victims to police would be exposing them to a tedious court process that may not be fruitful in the end. In Kenya, where service providers at the GBVRCs focused more on a victim's health and mental well-being, such decisions were taken based on the belief that it is not in the best interest of victims to go the through the criminal justice system. Moult's work on discretion as exercised by court clerks in South African courts shows that front-line

[858] Group interviews with sexual violence victims KE.D.6 on 5th February 2016.

implementers who may not consider themselves typical criminal justice actors also 'routinely adapt policy to serve what they perceive to be in the best interests of the complainant (client), and/or to serve their own pragmatic needs'.[859]

This decision-making by health workers to redirect the case, based on what they perceive to be pragmatic or in the best interest of the victims, also operated in the opposite direction: where victims are nudged to pursue criminal justice. As described earlier, there were instances when health workers and counsellors took decisions to encourage victims to report and follow up their cases because they believed this was in the best interest the victims and society. This was more pronounced in South Africa where the integration approach is oriented towards enhancing criminal justice system outcomes.

7.8. Conclusion

While integration models operate as safe havens for victims of sexual violence, they are not free from flawed social, economic, legal and institutional systems into which they are embedded. This chapter shows that both TCCs and GBVRCs create safe havens by integrating health, legal and psychosocial services in a way that linked victims to specialised services and structures seeking to safeguard them from difficulties of mainstream processes. However, challenges of socio-economic, legal, cultural and religious systems continue to negatively affect how the centres seek to protect women. In addition, the discretion of service providers is one way through which these systemic flaws permeate the safe havens, since the decisions of case managers, health workers and counsellors are influenced by these systemic and structural flaws.

Due diligence at the systemic level requires state interventions to build the capacity of service providers and address deeply-rooted institutional norms that normalises violence against women, despite the formal availability of services. This responsibility recognises that when states fail to hold perpetrators accountable due to corrupt systems, persistence of gender bias and stereotypes of women as victims, then the state implicitly condones violence against women. Through such condoning, gender inequalities are reinforced, women lose faith in the

[859] Moult, K., above note 846.

justice systems, and social normalisation of sexual violence remains, causing the violence to continue. Therefore, a state does not fulfil its systemic-level due diligence responsibilities by simply establishing integration centres, but by holistically transforming the systems into which these specialised centres are embedded.

CHAPTER 8

TOWARDS A VICTIM-CENTRED APPROACH IN INTEGRATING SEXUAL VIOLENCE SERVICES

8.1. Introduction

In this thesis I argue that using a feminist human rights lens reveals that sexual violence service integration models in Kenya and South Africa operate system-centred approaches that front competing sector mandates, which eclipse the needs and rights of victims. Hence, integration, the approach acclaimed as a best practice, can compromise the fulfilment of state obligations to prevent and effectively respond to sexual violence, by de-centring the needs and rights of women victims.

In this last chapter I reflect on the service orientations emerging from the two comparative case studies; Kenya's Gender Based Violence Recovery Centres (GBVRCs) and South Africa's Thuthuzela Care Centres (TCCs) to suggest parameters for a victim-centred approach to service integration. Previous chapters have shown that gaps are created by the emerging orientations that skew the integration models towards prioritizing certain sector-specific outcomes, while diminishing others. In addition, although the integration centres aim to operate as separate, designated safe havens, protected from the flaws of mainstream institutions and structures, they remain embedded within these flawed systems. The integration centres are not immune to social, legal, cultural and economic system inequalities.

I draw from these arguments to suggest parameters for a victim-centred approach to integrating sexual violence interventions in resource-constrained settings. I argue that a victim-centred approach is one that is responsive to the specific, yet multiple needs of individual victims, while acknowledging the complexity of victims' experiences and vulnerabilities. I suggest five considerations for a victim-centred integration approach arising from the TCC and GBVRC case studies. Such an approach requires us to acknowledge the multiple identities and experiences of victims, to re-consider the ambivalence of crisis centres, to broaden conceptualisations of punishment and redress, to take seriously the capacity and agency of victims and to alleviate the victims' burden in accessing services.

8.2. Acknowledging the Multiple Identities and Experiences of Sexual Violence Victims

A victim of sexual violence presenting at the health facility for treatment is a patient. When she reports at the police station, thereby entering the criminal justice system, she is a prosecution witness. When the same victim books an appointment for counselling or is otherwise referred for other psychosocial services, she is a client. When she joins various initiatives, such as victim support groups or economic empowerment programs run by women's rights organisations, she is a victim being turned into a survivor. Victims of sexual violence occupy multiple, pre-determined identities depending on where she reports, and the nature of service being provided.

Even in the context of integrated services, which essentially joins interventions through multi-sectoral collaboration, this thesis has shown that victims occupy different roles, assigned to them by the different sectors involved. Tensions arise as victims embody these multiple identities, concurrently, since they are likely to be at odds, depending on what each sector within a multi-sector collaboration aims to achieve. Vetten's work has found that South Africa's TCCs are contested spaces that 'attempt to mediate both the interests of the criminal justice system and the public health system, with the inclusion of NGOs adding yet another layer of complication.'[860]

Similarly, findings here have shown that different interests emerged based on how justice and adequate redress were defined by different stakeholders. For instance, in the TCCs, the Department of Social Development's (DSD) way of understanding victim assistance, support, and justice, differs significantly from what the National Prosecution Authority (NPA) considers the same to be. For the latter, the best form of victim support is achievable through expediting the criminal justice process and achieving successful prosecutions with stiff sentences. On the other hand, the DSD thought that justice, should it come from the criminal justice system, is less about getting cases through the court roll and more about ensuring the victim felt that she was heard, that she was given an opportunity to tell her story, irrespective of the judicial outcome.[861]

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[860] Vetten, L., above note 53 at 10.

[861] Interview with key informant SA.KI.3 on 6th June 2017.

We have also seen that in Kenya's GBVRCs, in certain instances, health workers and counsellors opted not to refer victims to the police for investigation, concluding that a victim's health and well-being is more important than the tedious criminal justice system. These service providers concluded that police investigation and prosecution was simply not in the best interest of the victims, given the reduced prospects of successful prosecutions, due to the lack of forensic or other 'obvious' evidence of rape.

What becomes apparent here is that, while different stakeholders or sectors may believe themselves to be operating in a victim-centred approach, there are several meanings of what this approach is, given the multiple, pre-determined identities conferred on victims. That is, from a service systems perspective, a patient-centred approach may not necessarily be a prosecution witness-centred approach. What then is a victim-centred approach? Is it possible to determine parameters of such an approach, in the context of multi-sector responses to sexual violence?

In this thesis I argue that a victim-centred integration approach is one that achieves 'collaborative advantage' based on how the multi-sector approach meets the multiplicity of victims' needs, rather than based on how sector-specific mandates are achieved, with the assistance of other sectors. The latter is a system-centred approach, which, by other forms of analysis, may seem effective, because, depending of the orientation, the sector whose outcomes (e.g. health, legal or psychosocial) are prioritised will be content.[862] However, the feminist human rights analysis reveals that such a system-centred approach, at best, only responds to some victim needs and fulfils only part of their rights. At worst, orientations that are skewed towards prioritising responses to some victim needs and rights over others may expose victims who disclose or report sexual violence to more victimisation or insecurity. For instance, an emergency-focused response may encourage reporting and provide crisis services, but a lack of follow up of legal and psychosocial support may compromise victim safety due to retaliation by perpetrator or community.[863]

[862] VanDenBerg, E. J. & Grealish, M., above note 165.
[863] Garcia-Moreno, C., above note 132.

Beyond these professionalised, pre-determined, system-centred identities conferred on victims, the reality of intersecting inequalities often means women's experiences of sexual violence are compounded by several other forms of oppression.[864] Due to structural inequalities, poor, Black women and girls, the characteristic demography of populations seeking services at these centres, face additional challenges of systemic poverty, unemployment, lack of housing and social security.[865]

A victim-centred approach to sexual violence service integration is one that remains cognisant of this complexity and the multiplicity of victims' needs, varying in nature and priority with each case. The core element of a victim-centred approach requires the basic process of asking victims what they need, which may seem rather obvious, but as this study has shown, is not quite so, in the midst of competing sector mandates and pre-determined identities conferred on victims.

8.3. Moving Beyond Criminal Justice to Broad Conceptualizations of Adequate Redress for Sexual Violence Victims

In both country case studies, integration centres apply limited conceptions of punishment that focus on criminal justice and the imprisonment of the perpetrator, with absent considerations for victim redress and reparations. Sexual violence against women is not only a crime, for which a criminal justice system response is necessary, it is a violation of fundamental human rights. Narrowly conceptualised punishment regimes that prioritise retribution, focus on the perpetrator and the state, as prosecutors keep the woman to whom direct harm was occasioned, at the periphery of the justice system.[866] This way of thinking is part of the colonial legacy, following the rise of the centralised state, which favours the notion of a crime as something committed against the state.[867] This system emphasises punishment

[864] Bennett, J., above note 771.
[865] Yuval-Davis, N., 'Intersectionality and feminist politics' (2006) 13.3 *European Journal of Women's Studies* 193.
[866] Walklate, S., above note 322.
[867] Mawby, R. & Gill, M., *Crime victims: Needs, services, and the voluntary sector* (1987). These authors document the colonial developments of criminal law and subsequent distinctions between criminal and civil law which led to the exclusion of victims from criminal justice.

and the imprisonment of the perpetrator as well as financial payment to the state in the form of fines, to the exclusion of compensatory, restorative and rehabilitative forms of justice.[868]

A victim-centred approach requires broader conceptualisations of punishment, which think beyond the criminal justice system to include civil and administrative remedies and to ensure 'effective protection, support and rehabilitation services for survivors of violence.'[869] Redress mechanisms should ensure negative consequences for perpetrators, while remaining cognisant of the safety and security needs of victims, with the overall aim being to provide an adequate remedy for violation.

In the practice of implementation, front line service providers in both countries, working to integrate sexual violence services, are operating within very narrow conceptualisations of reparations for sexual violence. The criminal justice system was the only legal form of redress that victims who were supported through these centres were allowed, if not vehemently encouraged to pursue. Conviction and imprisonment were not only assumed to be the central meaning of 'justice', but the only possible way to recognise the victim's harm. This centrality of criminal justice is premised on a system-centred mentality, which insists that victims would not want or need anything else other than the conviction and imprisonment of the perpetrator. Holding perpetrators accountable for crimes committed fulfils the state's obligations to prosecute and punish, and meets the safety and security needs of victims by having the perpetrators removed from society. However, the sole focus on criminal justice eclipses the multiple other needs of sexual violence, covered under the broader human right to effective remedies and adequate reparations.

A victim-centred integration approach should move beyond criminal justice to incorporating broader conceptualisations of redress that include restitution, compensation, rehabilitation, satisfying what a victim needs, including guarantees of non-repetition. This holistic outlook ensures that integration models also contributes to the other state obligations to protect,

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[868] Hatchard, J., 'Victims of crime and abuse of power in Africa an overview in victims and criminal justice' in Kaiser, G., Helmut K. & Hans-Jörg A. eds., *Victims and criminal justice: Legal protection, restitution, and support* (1991).
[869] Manjoo, R., above note 336.

prevent and provide adequate redress. Guarantees of non-repetition have especially been noted as having the greatest potential for transforming gender relations:

> Promising to ensure non-recurrence, triggers a discussion about the underlying structural causes of the violence and their gendered manifestations and . . . about the broader institutional or legal reforms that might be called for to ensure non-repetition.[870]

In practice, as in academic discourse, the conceptualisations of adequate remedies for sexual violence remain nascent and aspirational, but not functional.[871] Manjoo has argued that reparations for sexual violence against women should be 'transformative both in process and in substance for victims of sexual violence'.[872] In terms of integrated sexual violence services, this means that the operations of the centres should facilitate safe processes for women to pursue and access other forms of reparations. State obligations of due diligence at the individual level require that the integration centres be flexible and to include victims' perspectives and participation in deciding which reparation options will enable a victim to move on and rebuild their lives.

State obligations of due diligence at the systemic level require states to create legal, institutional and structural environments that allow for such integration centres to functionally implement these broader conceptualisations of reparations. This can be done through reforms to rigid legal frameworks,[873] including directives that clarify what reparations for sexual violence victims look like, coupled with 'systematic training to build capacity of legal institutions and other stakeholders including police, prosecutors, health workers and social workers.'[874]

Victim-centred integration approaches can also facilitate adequate redress by taking into account 'the multi-dimensional and long term physical and psychological consequences of

[870] Ibid.
[871] Manjoo, R., above note 70
[872] Ibid.
[873] Ibid.
[874] Ibid at 1197

sexual violence against women and their families and communities'.[875] For example integration centres should consider including support services for families of sexual violence victims, thereby acknowledging that the victim of harm is often not the only one affected, so as to address the 'community of harm'.[876]

8.4. Enabling Victims' Capacity and Agency to Participate

A victim-centred integration approach is one that allows the victim to take the lead as the driver of their justice-seeking and restorative process.[877] Multi-sector collaborations are expected to improve the quality and continuity of services through keeping victims informed and updated on the progress of their cases. It is important to create avenues for victims' input in the process of seeking recourse. This requires respecting the victims' right to information concerning all decisions that are made with regards to their case. As noted earlier, the common perspective expressed by service providers is that rape victims are not involved because they simply do not know how the justice system works. Saying for example 'unfortunately complainants are ignorant, even though we try our utmost to explain to them the court proceedings and the justice system, they don't really grasp it.'[878] Respecting victim's capacity means acknowledging that victims are not foolish, ignorant people who cannot understand the justice-seeking process, if it is explained to them. This means finding ways to keep the flow of information to and from victims, by including their voices and centring their interests in the pursuit of recourse.

The thesis findings have shown that the gaps in information when victims are not updated on case progress can lead to traumatisation, for example, when the victims see perpetrators back into the community, having been released on bail or parole. However, most service providers described victims as having unrealistic expectations to be kept informed and involved of every process when 'there is not sufficient manpower to go to the complainant's house every day

[875] The Nairobi Declaration on Women's and Girls' Right to a Remedy and Reparation. Signed at the International Meeting on Women's and Girls' Right to a Remedy and Reparation, held in Nairobi from 19 to 21 March 2007.
[876] Manjoo, R., above note 70.
[877] With the rise of victimology and the victim's rights movement, advocates and scholars have challenged the idea that victims are nothing more than sources of evidence. Victims' rights to information, participation and services. Crawford, A. & Goodey, J., eds., *Integrating a victim perspective within criminal justice: International debates* Vol. 3 (2000).
[878] Interview with case manager SA.A.4 on 24th October 2016.

and go and give her an update.' Several providers in both countries explained the opinion that victims unfortunately change addresses, cell phones without informing them.

Indeed, both the GBVRCs and TCCs are operating within resource-constrained settings with limited capacity. However, keeping victims informed, and enabling their agency and capacity is more a question of strategy and mentalities underlying service integration, and less about the resource context. For example, one participant explained how she challenges the isolating effect of the criminal justice system to 'make a victim feel that she is actually the leader of the team'.[879] She said:

> We're trying to fulfil her (victim) needs, so during the legal consultation, I ask what her expectations of the legal process are. I say to her: "you are the driver of this train, it's not a runaway train, it can stop at any time, it can change track." I use that kind of analogy to engage with them and give them the power.[880]

This case manager went on to explain that this was her method of creating an opportunity where victims can take back the power which was taken away during the sexual violence they experienced. This case manager's approach and perspective is an example that fosters the right of victims to participate in the justice-seeking process.

This case manager also involved victims in the prosecutorial decisions and processes, even where such decisions are not in favour of the victim. For example, she 'takes a step further to schedule an appointment with that victim or her guardian and explain to them the reasons for not prosecuting the case, whether or not she (victim) agrees, also I explain to them that they do not to have to accept my decision.' The case manager provides victims with 'details of our provincial office through which they can have the decision reviewed'. This approach enables victim's capacity and agency, by informing them of accountability mechanisms through which complainants can review decisions of legal officers should they disagree with them.

[879] Interview with case manager SA.C.3 on 15th March 2017.
[880] Ibid.

This was a rare perspective, not encountered again in the other three of South Africa's TCCs and in all Kenya's GBVRCs. This case manager's experience shows that it is possible to implement a victim-centred approach that enables victims to not only express their expectations but to take leadership of the justice-seeking process. The failure to acknowledge and enable the agency and capacity of sexual violence victims' compromises their right to adequate redress in the justice-seeking process. As noted earlier, the victim impact statements emerged as the only available avenue for victim participation, which often comes too late, at the sentencing stage, and is treated as an afterthought.

Victims' rights scholars have argued that there is a need to create more opportunities for victims to participate in the justice process.[881] For example, Smythe has argued that legal representation for sexual violence victims is one approach to ensure a victims' interest are kept central in criminal justice processes. [882] In Kenya the victim's rights legal framework has progressed significantly with the enactment of the Victim Protection Act, which enshrines the right to information and participation, including through a legal representative.[883] Similarly, South Africa's Victims Chatter sets out the right of victims to give and receive information, to receive assistance and protection. However, the vagueness of these provisions makes it 'unclear the extent to which service providers should enable victim participation to ensure victims' interests are central to justice processes'.[884]

Another missed opportunity for victims' agency and participation is with regards to parole hearings. As noted, in of all the eight centres in both countries, only one TCC involved the correctional services as part of their multi-sector collaboration network, by ensuring victims participate in the parole process. A victim-centred integration approach is one that extends its relevance beyond criminal conviction and considers the impact of the release of

[881]The victims' lack of formal legal status in adversarial legal systems is largely due to fears that victim participation will affect the accused's fair trial defence rights. This has been contested by scholars who argue that there are different forms of participation ranging from; 'decision making control, to processes of providing information to victims and allowing victims to express themselves. Not all these forms of participation are dangerous to the accused's defence rights or inapplicable in adversarial systems. These scholars argue that to deny victims all forms of participation is to 'assume that victims' needs will always coincide with those of the prosecution.' Wolhuter, L., Olley N. & Denham, D., *Victimology: Victimisation and victims' rights* (2008) at 196

[882] Smythe, D., above note 744.

[883] Kenya Victim Protection Act 2014.

[884] Faull, A. & Mphuthing, P., above note 741 at 128.

perpetrators on victims. Therefore, including departments of correctional services as part of the multi-sector collaboration contributes to fulfilment of the state obligations to punish and provide adequate redress.[885]

8.5. Lifting the Victims' Burden

A victim-centred integration approach is one that alleviates the burdens that victims are likely to bear in the process of seeking recourse and support services. Multi-sector approaches that integrate sexual violence services are expected to generate a more effective response by lifting victims' burdens, which are prevalent in the contexts of under-reporting, high attrition, and secondary victimisation, due to discriminatory practices and attitudes.[886]

However, the emerging orientations in both Kenya and South Africa show that gaps are created by service orientations that prioritise some sector outcomes over others, putting burdens on victims seeking recourse. Kenya's GBVRCs weak linkages between the health and legal sectors puts a burden on victims in terms of moving from one stakeholder to another just to get the medico-legal documentation filled in. This leads to a tedious process that requires victims to move back and forth, from health facilities to the police station, sometimes travelling long distances. In Nairobi, this tedious journey has the extra burden of going to the police surgeon based on the practice fallacy that only they can complete the form for it to be accepted as evidence in court. This is despite a clear stipulation in the national guidelines that any registered government health practitioner can fill in the forms, as is the practice in the GBVRCs in other counties, outside Nairobi.[887]

This challenge is exacerbated by the GBVRCs' collaboration systems that integrate services at the service provider's level, but not at the systems levels, which makes it difficult for cross-sector referrals between health and legal institutions to be done systematically. Therefore, even with the best efforts of partnership among service providers, the collaboration networks struggled with effective referrals because of the absence of linkages at the institutional levels. Colombini and other scholars have argued that this lack of systems-level integration is a

[885] Abdul Aziz, Z. & Moussa, J., above note 47.
[886] Wolhuter, L., Olley N. & Denham, D., *above* note 881 at 141.
[887] Kenya Sexual Violence National Guidelines, above note 4.

barrier to effective service integration since it leads to weak referral systems.[888] The burdens placed on victims, due to these gaps in integration, falls within the remit of a state's obligations to protect, prosecute and punish sexual violence. In addition to the difficulties of the back and forth victim journey, which cause delay, it risks the exposure of victims' privacy, compromising victim confidentiality and safety.[889]

The TCCs weak linkages to ongoing psychosocial services and the lack of mechanisms to sustain contact with victims also puts a burden on victims to individually pursue any other continued support services that they may need after the first TCC visit. The lack of follow-up mechanisms places undue burden on TCC victims to individually find other places for continued health services and counselling. I have problematized the common mentality underlying TCCs' lack of follow-up strategies, which is that victims may not want to be contacted again, or that follow up compromises the process of victim agency and empowerment, which allows victims to choose whether or not they want to seek additional support services.

The resource-constrained context in which the TCCs are operating shows that in reality, the options are already limited in terms of provision of psychosocial support services.[890] Therefore it is less a question of whether or not sexual violence victims should be allowed to opt whether or not they want to receive long-term psychosocial support, though important. It is a question of whether the state is proactively implementing strategies that assure victims of the availability of long-term support services, when they are ready to receive them. Faull and Mphuthing have argued that in the context of South Africa, the vagueness of the Victims' Charter, which does not give victims any legal rights to receive support services, has the effect of placing undue 'onus on the victim to request services, rather than on the government and service providers to provide these services'.[891]

[888] Colombini, M., Dockerty, C. & Mayhew, S., above note 30.
[889] Abdul Aziz, Z. & Moussa, J., above note 47.
[890] Vetten, L., above note 53.
[891] Faull, A. & Mphuthing, P., above note 741 at 128.

This passive approach to service integration compromises the fulfilment of state obligations to protect victims because it compromises availability and quality of services. It compromises the obligation to prevent because the lack of long-term psychosocial support can keep victims in cycles of violence, exposing them to more safety risks after reporting, or because of reporting. It also compromises the fulfilment of the state obligation to provide adequate redress, which includes ensuring access to comprehensive restorative processes of physical and mental healing.

8.6. Re-Considering the Ambivalence of Crisis Centres

A victim-centred integration approach needs to move beyond emergency response. Literature on integrating sexual violence services has shown that in low- and middle-income countries, integration developed mainly under the ambit of one stop crisis centres (OSCC).[892] As part of health systems responses, the essential component of this OCSS approach was to focus on 'crisis' responses to sexual violence.[893] The question of whether the OSCC models aim to, or are even capable of providing follow up and long-term care beyond the emergency services needs to be reconsidered.

In Chapter Five, I showed that the design and operations of South Africa's TCCs is oriented towards emergency response with significantly limited mechanisms and regard for providing long-term support. In comparison, Kenya's GBVRCs incorporated some mechanisms to facilitate long-term support such as victim support groups and victim empowerment programs. However, like the TCCs, Kenya's GBVRCs had minimum resources invested in terms of long-term support and follow up, making long-term support mechanism available to only a few victims within the proximity of the centres.

Improving emergency response to sexual violence is critical because the first few hours of a sexual violation are an emergency and require crucial attention for treatment, evidence collection, responding to trauma and securing victims from harm. In this way emergency response services contribute to the fulfilment of state obligations to protect, prevent

[892] Colombini, M., Mayhew, S. & Watts C., above note 63.
[893] Ibid.

(secondary) and increase chances of successful prosecution through obtaining forensic evidence. However, scholars have critiqued the emphasis on safeguarding the reporting stage and responding to the emergency cases without clear strategies for addressing needs and rights of victims for the mid to long term.[894]

Notable is that since 1994, when Malaysia's OSCC was established, which is the first model in low- and middle-income countries, the word 'crisis' seems to have fallen off the terminology of subsequent models. The models in Sub-Saharan African countries are now generally referred to as 'one stop centres' (OSC). This removal of the 'C' for crisis needs to mean more, in terms of re-conceptualising integrated sexual violence services to respond to multiple and complex victims' needs that transcend the moment of emergency or crisis. A victim-centred approach considers not only the benefits, but the challenges of emergency-focused responses, which only improve experiences of victims at the point of reporting.

For example, emergency responses, much like in the post-rape care service discourse, only respond to a particular script of sexual violence experiences. The design of emergency post-rape care emphasises strategies for responding to rape that is reported promptly – within 72 hours - where a frantic victim is contained by receiving a few minutes of containment counselling, emergency treatment and a medical examination is conducted to collect forensic evidence and the victim is assisted with reporting to the police. This focus can lead to integration approaches that are responsive to the 'real rape' stereotype while remaining incapable of responding effectively to the circumstances of other rape cases.[895] In this way, service integration centres can operate in ways that eclipse the different needs of, for example; victims of cold rape cases; who may not be frantic and in need of containment; who do not need forensic medical examination because it's too late for forensic evidence, or who do not want to report to the police.

[894]Smythe, D., above note 36; Vetten, L., above note 53.
[895] Estrich, S., above note 777.

8.7. Conclusion

In this chapter, I have considered the difficulty of defining parameters for a victim-centred integration approach in the context of multi-sector collaborations. Drawing from the discussions on emerging service orientations in Chapter Six and the persisting systemic and structural flaws embedding the integration centres in Chapter Seven, I proposed five suggestions on what a victim-centred service integration approach may look like. At the core of this approach is the need to acknowledge the multiple identities and diverse experiences of women who experience sexual violence, by allowing the victims voices to lead the process of restoration. This requires implementing integration approaches that enable victims' capacity and agency, move beyond criminal justice to conceptualise broader forms of punishment and redress, and ease the victims' burden when seeking recourse. There is also a need to re-consider the ambivalence of the crisis centres in sexual violence service integration. While crisis response is necessary to meet the emergency needs of victims, a victim-centred integration approach is one that is designed to equally address the mid-to long-term needs of victims.

CHAPTER 9

CONCLUDING REMARKS

In this thesis, I set out to understand how integration models in Kenya and South Africa contribute to the fulfilment of state obligations to prevent and effectively respond to sexual violence against women. My central argument is that multi-sector approaches that integrate sexual violence services are complex endeavours, which produce different orientations shaped by the interactions of collaborating partners, amidst fundamental structural and systemic flaws. In the context of competing sector ideologies, service-integration approaches can eclipse, and de-centre victims' needs and rights as they focus on achieving sector-specific mandates and outcomes.

I have argued that a victim-centred integration approach achieves 'collaborative advantage'[896] based on how the multi-sector approach addresses the multiple needs and rights of victims, rather than achieving sector-specific mandates, through the assistance of other collaborating sectors. The latter is a system-centred approach, which, by other forms of analysis, may nonetheless be argued as effective, because, depending on the orientation, the sector whose outcomes are prioritised will consider the integration approach successful.

As discussed in Chapter Two, existing literature on service integration largely analyses 'success' or 'effectiveness' of integration models based on how sector-specific outcome indicators are fulfilled through multi-sector collaborations. Studies have either focused on service integration as a means of improving health outcomes, including mental health, or as a means of improving criminal case management to increase conviction rates. These analyses reflect the priorities of individual service systems, and as such, may well regard achievement of the respective sector mandates as a collaborative advantage.

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However, a feminist human rights perspective reveals that such system-centred approaches, at best only respond to some victims' needs and fulfils only part of their rights. At worst, service orientations that are skewed towards prioritising some victim needs and rights over

[896] This is the desired outcome of any collaboration. This 'advantage' is gained when something is achieved that could not have been achieved by any one organization or sector acting alone. Huxham, C., above note 82.

others may expose victims, who report sexual violence, to the danger of re-victimisation. For example, emergency health service-focused responses may encourage reporting and provide crisis responses, but the lack of follow up and continued support compromises victim safety, exposing them to the risk of retaliation and re-victimisation.

To discuss the different orientations emerging from Kenya's GBVRCs and South Africa's TCCs integration approaches, I drew from literatures on collaboration and nodal governance theory. I have argued that the different integration approaches in the comparative case studies are service orientations, which are produced based on how stakeholders or sectors as a nodes within the networks, wield their capacities to influence the outcomes of the networks. These stakeholders use their institutional structures, resources, mentalities and methods to shape and incline the networks towards prioritizing certain outcomes over others.

South Africa's TCC integration model, situated within the ambit of National Prosecuting Authority as the lead agency, is invested towards increasing positive criminal justice system outcomes. Subsequently, as prosecution and conviction take priority and other sectors are aligned towards furthering this key agenda, strategies for long-term comprehensive health and psychosocial care remain weak. Conversely, Kenya's GBVRCs have significant investment towards improving comprehensive health care including long term psychosocial support through state and non-state partnerships within the health sector. Consequently, as improved health outcomes and victims' well-being take priority as outcomes, linkages to legal and justice sectors remain weak.

Despite these differences in service orientations, some orientations are similar in both country approaches. They are both oriented towards emergency or crisis responses, rather than long-term care. Both country models are also more inclined towards response than prevention, despite undertaking some prevention-related activities, which remain sporadic and without clear, sustained strategies.

9.1. Implications for Individual- and Systemic-level Due Diligence

Using a feminist human rights perspective based on the state's responsibility to exercise due diligence to prevent, protect, prosecute, punish and provide adequate redress, I have

considered how these orientations eclipse and de-centre the needs and rights of sexual violence victims'. This analysis framework reveals how the models contribute towards or compromise fulfilment of these state obligations.

South Africa's TCCs criminal justice system orientation has established systematic linkages that integrate emergency medical treatment and examination, containment counselling, the processing of forensic evidence, completion of medico-legal documentation, specialised police investigation, and prosecution. This orientation contributes to the fulfilment of state obligations to prosecute and punish. The prompt provision of emergency support services also partly contributes to fulfilling the obligation to protect, and secondary prevention through early detection of violence, after which victims can be referred to safety and other support services.

However, the TCCs criminal justice system-focused orientation, which assesses success based on increasing conviction rates, leads to cases being 'selected for success',[897] hence facilitating the real rape stereotype in prosecutions. This compromises the fulfilment of the state's obligation to prosecute and punish all sexual violence cases, due to the stereotypes applied in this process of case selection. In addition, this orientation eclipses and de-centres victims' needs to comprehensive health care and long-term psychosocial support. The unequal involvement of social service actors within the TCC leads to weak linkages to shelter services and poor investment in continued counselling services, which makes the model unresponsive to victim's mental health, safety and security needs.

Furthermore, the TCCs' focus on emergency medical treatment makes the model unresponsive to victims' needs for follow-up treatment, including access to and completion of PEP. The referral system and follow-up method that only tracks the progress of cases in the criminal justice system does not monitor the progress of the victim's health and psychosocial needs. In these ways the TCCs' emergency and criminal justice system orientation compromises fulfilment of the state's obligation to protect, by failing to address long-term health and psychosocial needs of victims.

[897] Schonteich, M., above note 802.

This emergency, criminal justice-focused orientation of the TCC does not have effective means of sustaining contact with victims other than cases that are being prosecuted. This makes the model unresponsive to the needs of victims outside the criminal justice system. In these ways the TCCs' orientation responds to the needs of a narrow script of sexual violation. It eclipses the needs of victims who do not report to the police, who use other pathways to seek support services, and the victims of cold rape cases. This orientation compromises state obligations to protect, prosecute, punish and provide redress services to all sexual violence victims.[898]

Therefore, by design, the TCC model lacks strategies for sustaining contact with victims other than those whose cases are transmitted through the criminal justice system. From understanding this TCC design, it is unsurprising that during my research I was not able to access TCC victims to participate in this study, in the same way that I was able to do with the GBVRCs, which have strategies of sustaining contact with victims through victim support groups. A victim- centred approach requires that there should be an avenue for sustaining contact with victims so that their voices and experiences provide feedback to improve the integrated services.[899]

Kenya's GBVRCs are focused on comprehensive health care, including long-term psychosocial support. This orientation contributes to fulfilment of the state obligation to protect by providing both emergency and long-term support services. Through continued counselling sessions and victim support groups the GBVRCs model has sustained contact with victims, including follow up for referrals to additional social services. Through these follow-up strategies, the GBVRCs also monitor and provide continued health services and treatment, including monitoring victims' adherence to PEP. This provision of comprehensive health services also contributes to fulfilment of the obligation to secondary prevention by creating opportunities for early detection of violence and prompt referral to safety and support

[898]Abdul Aziz, Z. & Moussa, J., above note 47.

[899] A recent study found that as of March 2017, there was no single coordinated platform through which TCCs rape victims could provide feedback of post-rape services received through the TCCs. Johnson, S., Mahlalela, N.B. & Mills, E., *Client experience of rape victims accessing governmental post-rape services in South Africa,* 2017.

services to avoid reoccurrence. In addition, The GBVRCs linkages to economic empowerment programs, education activities and community resource structures, such as women's empowerment programs, gives women the opportunity to break the cycle of violence contributing to the obligation of the state to prevent violence. In these ways the GBVRCs model address victims' physical, psychological and safety needs, while challenging the isolating effects of violence by linking victims to community support structures.

However, this orientation has weak linkages to legal and justice sector responses, which compromises the ability to hold perpetrators accountable for sexual violence. The lack of systematised linkages between the health services and police investigations puts undue burdens on victims who pursue prosecution. Victims spend several hours, sometimes days, moving between health and legal sector service points to get basic medico-legal forms completed. The lack of linkages to court prosecution processes makes it impossible to track the progress of the cases, supported through the GBVRCs, in the criminal justice system. In these ways, the orientation of the GBVRCs' compromises the fulfilment of the state's obligation to prosecute, punish and provide adequate redress to sexual violence.

The discussion on orientations has implications for understanding how integration models contribute to fulfil the state responsibility to act with due diligence at individual level. Individual due diligence is concerned with meeting the specific, yet multiple and complex needs of victims with flexibility, in a way that allows women victims to move on and rebuild their lives. This analysis shows that an integration approach that fulfils all these state obligations is one that centres the needs and rights of victims, because the fronting of competing sector mandates hinders a model's flexibility to respond to all the multiple victims' needs.

Therefore, although South Africa's TCCs and Kenya's GBVRCs have different orientations, they are quite similar in the end, because, to a large extent, they both foreground the priorities of service systems, whether criminal justice, or health systems, over the multiple victims' needs. In addition, although they both seek to operate as safe havens, they are not removed from broader, mainstream, systemic and structural flaws that embed them. Beyond orientations, a victim-centred integration approach is one that operates in full consciousness that the

creation of safe havens will not, of itself, result in any meaningful response to victim's needs and rights, if the systemic flaws and structures within which they operate are not addressed.

The integration centres as spaces of comfort, warmth, and safety, seek to restore victims' dignity after sexual violence through protected, separate structures and processes. However, in both country contexts, the models are affected negatively by socio-economic, cultural, religious, legal, institutional and geopolitical systems and structures within which they remain embedded. In both countries, the narrow focus on criminal justice responses to sexual violence as the ultimate form of justice compromises fulfilment of the broader state obligation to provide adequate redress. This is because both have limited the conceptualisations of punishment and absented considerations for victim reparations and other redress options.

Huxham and Vangen coined the useful term 'collaborative inertia' to describe the unfortunate scenario of multi-sector collaborations not achieving any significant positive outcome despite the best efforts of all network partners.[900] This thesis shows that despite the best efforts of all sectors and stakeholders involved, sexual violence service integration models will continue to compromise the fulfilment of human rights-based state obligations to address sexual violence, if systemic inequalities are not addressed. Therefore, beyond orientations, a victim-centred integration approach is one that fulfils not only individual-level, but also systemic-level due diligence. This requires states to ensure a sustainable and holistic approach of addressing violence against women, by targeting root causes, through transforming negative institutional norms and social attitudes.

Such a holistic approach is one that focuses on prevention and not only response, as Chapter 6 of this thesis has shown. In addition, challenging systemic inequalities can be achieved by implementing the suggested parameters for victim-centred service integration such as moving beyond criminal justice to broadening conceptualisations of punishment and redress. This requires states to consider the ambivalence of crisis centres that do not have the capacity to meet victims needs on a long-term basis. Integrated interventions should also acknowledge

[900] Huxham, C. & Vangen, S., above note 82.

the complex and multiple needs of victims, thereby enabling their capacity and agency, so that victims can lead their own process of seeking recourse without unnecessary burden.

In addition to these parameters which are discussed in Chapter 8, these integration models need to be well resourced. The lack of financial resources and capacity, including lack of enough personnel and basic utilities inhibits the potential of these multi-sector agencies. Funding is essential to improving the implementation of service integration through multi-sector collaborations. While this study did not collect specific data on the funding streams, there is a need to understand the different funding strategies that are resourcing these models. This is a critical area for future inquiry. Such an inquiry should consider how the different financial responsibilities of the multiple sectors working together can be harmonised in a way that responds to the needs and rights of sexual violence victims.

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APPENDIX A

INFORMATION SHEET (FOR SERVICE PROVIDERS)

Research Title: 'One Stop Centres' and State Accountability for Sexual Violence against Women: Comparing Service Integration Models in Kenya and South Africa

My name is Ruth Nekura. I am a student conducting research towards a doctoral degree (PhD) in Public Law at the University of Cape Town, South Africa. The study aims to evaluate the effectiveness of Kenya's integration models working to address sexual violence in comparison to South Africa's Thuthuzela Care Centre (TCC) model in order to assess how the integration models operate in different service contexts. In determining effectiveness therefore, the proposed research will evaluate integration models based on their contribution to the fulfilment of the state obligation to act with due diligence to prevent, protect, prosecute, punish and provide adequate redress to sexual violence victims. I am interested in understanding how these integrated service provision models operate in practice and how well they respond to sexual violence against women and girls.

I have identified your organisation as one with expertise that could inform the research project and I would therefore like to interview you about your experience and work in this area. The key areas that the interview will cover are;

- The services offered at your organisation, or activities towards prevention and/or response to sexual violence against women and girls.
- How service provision is integrated among relevant sectors. i.e. health, legal and psychosocial services, and how that affects the victims experience in the criminal justice system.
- Challenges and opportunities that arise in integrating services for sexual violence victims, in order to identify potent characteristics of an effective and sustainable integration model for resource poor settings.
- The service delivery experiences of sexual violence victims seeking recourse and who were supported through your organisation.

The findings of the research project will be written up and shared with you to enrich the programmatic and advocacy work at the GBVRC's on improving state accountability for sexual violence against women and girls. You have the choice of remaining anonymous if you do not wish to be named in the research report, and any data collected from the interview will not be shared without your approval. The interview will take roughly one hour and I will contact you to agree on a mutually convenient time and location for this to take place.

Please let me know whether you are willing to be interviewed for the research project. If you have any questions or concerns, please contact the researcher at ruth.nekura@gmail.com or lkkrut001@myuct.ac.za or call at +254724699931 (Kenya) and +27826245468 (South Africa)

If you have any concerns about the research, its risks and benefits you may also contact:

- University of Nairobi – Kenyatta National Hospital Ethics and Research Committee at 2726300 ext. 44102, Prof M.L.Chinda, Secretary KNH-UON ERC, Esther Wanjiru, at email uonknh_erc@uonbi.ac.ke
- University of Cape Town Law Faculty Research Ethics Committee Administrator, Mrs Lamize Viljoen, at (+27) 021 650 3080 or at lamize.viljoen@uct.ac.za. Alternatively, you may write to the Law Faculty Research Ethics Committee Administrator, Room 6.28 Kramer Law Building, Law Faculty, UCT, Private Bag, Rondebosch 7701.'

APPENDIX B

CONSENT FORM (FOR SERVICE PROVIDERS)

[Interviewer to read]

I would like to read the following information to you and for you to confirm at the end that you voluntarily consent to participating in the interview.

1. The researcher, Ruth Nekura has explained to me that the purpose of my participation in this interview is to gather information on the effectiveness of this organization/centre in address sexual violence against women and girls. The interview will cover subjects such as the services provided at the centre how the different service providers work together and challenges and opportunities in integrated service provision.
2. I understand that my contributions to this interview will be recorded, either by writing or audio-recorder.

3. I understand that there is no financial reward or compensation for participating in this research.

4. I understand that my participation in the interview is voluntary, and that I can stop participation at any time without consequence. I can decline to answer any question without penalty.

5. I understand how the information I give at this interview will be used.

6. I have received an Information Sheet with contact details of the researcher in case I would like further information about the project.

   Do you consent to participate in this interview? ☐ Yes ☐ No

   _____ _____

   Name of Research Participant Signature: Participant

   Date_____

APPENDIX C

INTERVIEW SCHEDULE (FOR SERVICE PROVIDERS)

A. Introduction

1. Which organization/centre do you represent and what is your role?

B. Prevention

1. What types of prevention activities do you conduct?

   Probes; *Describe any community awareness, advocacy or education programs on sexual violence that you conduct? Do you have a prevention strategy/ action plan? How, when was it developed and how often is it reviewed? (Do you there a sustained action plan?)*

2. How do you collaborate with organizations/ government agencies that do this? (If yes who and how?)
   Probes; *Do you collaborate with organizations/government agencies that implement other prevention strategies e.g. reducing risk factors by economic empowerment programs? (Who and how?)*

3. How does your work contribute to the modification of attitudes, behaviors that propagate sexual violence? Probes; *who are your target groups? How do you engage them? (victims, communities, schools, men)*

C. Protection

4. Describe the services do you offer to sexual violence victims?
   Probes; *Which are offered on-site? Off-site? Referral? (Are they short, medium or long term)*
   Approximately how long does it take for a victim to be served or to access these services (from the time you receive a sexual violence case)

5. How do you handle and disseminate victims' and case related information?
   Probes; *Are your services to victims of sexual violence confidential? How do you ensure privacy? How do you assist the victims with necessary information related to trial such as hearings, bail applications and rulings?*

6. How do the different sectors (Health, Legal, Justice, and Social) co-ordinate in protecting sexual violence victims?
   Probes; *How do the different service providers collaborate in providing these services to sexual violence victims?*

7. Do you conduct any stakeholder trainings on how to respond to sexual violence cases? If so, describe the trainings Probes; which stakeholders? Does your training address attitudes, myths and stereotypes which cause secondary victimization of sexual violence victims?

D. Prosecution

8. Which role do you play and do your services assist the victim in prosecution?
   Probes; *What process do sexual violence cases go through from reporting to prosecution? How is medico-legal documentation filled? How does the GBVRC/TCC assist in this? In sexual violence cases who is responsible for collection, preservation and storage of forensic evidence? Role in investigation?*

9. What collaboration do you have with the police, prosecutors and courts? How did this collaboration develop?
   Probes; *What are the benefits of your collaboration with the police, prosecutors, and courts? Who is responsible for ensuring your sustained collaboration with the police and the prosecutors? Any collaboration with specialized prosecutors or courts?*

10. Do you conduct any collaborative police and prosecutor trainings on how to handle sexual violence?

E. Punishment

11. Which options do you give to victims in terms of punishment of the perpetrator?

12. What challenges would you say affect the victim's quest for recourse? Probes; *of the sexual violence cases you supported in the last 12 months, how many resulted in conviction? What sentences were issued for the convictions?*

13. Do you collaborate with correctional services? If so how?

F. Redress

14. Describe the recourse options and support you give to victims, of sexual violence?
    Probes; *How do you assist victims of sexual violence to pursue the recourse they choose?*

15. What kinds of risks/challenges do victims face when seeking and recovering reparations? Probes; *How do you assist in them through these challenges?*

APPENDIX D

INTERVIEW SCHEDULE (FOR VICTIMS)

1. How did you find out about the GBVRC/TCC, who referred you?
2. Which services did you receive at the GBVRC/TCC or through referral from them? How long did it take before you received these services?
3. Can you describe your our experience of the services you have received here at the center?
4. Approximately how many people (service providers) did you speak to/were you referred to?
5. Did you feel that the GBVRC/TCC helped you feel safe from harm? How? (You felt the perpetrator has less access to you, was referred to a safe house etc.)
6. What did you feel you still needed?
7. Since your first visit at the GBVRC/TCC did the sexual violence reoccur?

APPENDIX E

INFORMATION SHEET (FOR VICTIMS)

Research Title: Evaluating Integration as a Means of Fulfilling State Obligation to Address Sexual Violence against Women in Kenya; *A Comparative Study of Integration Models in Kenya and South Africa*

My name is Ruth Nekura. I am a student conducting research towards a doctoral degree (PhD) in Public Law at the University of Cape Town, South Africa. I am researching on the effectiveness of Kenya's integration models, working to address sexual violence in comparison to South Africa's Thuthuzela Care Centre (TCC) model.

I am interested in understanding your experience in receiving integrated services at the GBVRC/TCCs, and how their services assisted you in seeking recourse or otherwise.

I am not going to ask you about any personal details or anything about the incident that gave rise to your case.

The key areas that our discussion will cover are;

- The services you received at or through referral by the GBVRC/TCC
- Your experiences in receiving the services at or through the support of the GBVRC/TCC
- How the service provision is integrated among relevant sectors, i.e. health, legal and psychosocial services, and how that (integration) affected your experience in the criminal justice system.
- Challenges and opportunities of receiving services through the GBVRC/TCC at different stages of seeking redress.

The findings of the research project will be written up and shared with the GBVRC/TCC to improve the quality of services they provide in addressing sexual violence and also used in advocacy work on improving state accountability for sexual violence against women and girls. You have the choice of remaining anonymous if you do not wish to be named in the research report, and any data collected from the interview will not be shared without your approval.

The discussion will take roughly one hour. In collaboration with the GBVRC/TCC, we have requested free counselling by referral to assist anyone who may feel upset as a result of taking part in the discussion.

Please let me know whether you are willing to participate in the discussion for the research project. If you have any questions, please contact the researcher at ruth.nekura@gmail.com or lkkrut001@myuct.ac.za or call at +254724699931 (Kenya) and +27826245468 (South Africa)

If you have any concerns about the research, its risks and benefits you may also contact:

- University of Nairobi – Kenyatta National Hospital Ethics and Research Committee at 2726300 ext. 44102, Prof M.L.Chinda, Secretary KNH-UON ERC, Esther Wanjiru, at email uonknh_erc@uonbi.ac.ke
- University of Cape Town Law Faculty Research Ethics Committee Administrator, Mrs Lamize Viljoen, at (+27) 021 650 3080 or at lamize.viljoen@uct.ac.za. Alternatively, you may write to the Law Faculty Research Ethics Committee Administrator, Room 6.28 Kramer Law Building, Law Faculty, UCT, Private Bag, Rondebosch 7701.'

APPENDIX F

CONSENT FORM (FOR VICTIMS)

[Facilitator to read]

I would like to read the following information to you and for you to confirm at the end that you voluntarily consent to participating in the interview.

1. The researcher, Ruth Nekura has explained to me that the purpose of my participation in this group discussion is to gather information on the effectiveness of this organization/centre in addressing sexual violence against women and girls. The interview will cover subjects such as the services provided at the center, my experiences in accessing these services, how the different service providers work together in providing services, and challenges and opportunities in integrated service provision. **It has been clarified to me that I am not going to be asked about any personal details or anything about the incident that gave rise to my case**

2. I understand that my contributions to this discussion will be recorded, either by writing or audio-recorder.
3. I understand that there is no financial reward for participating in this research.
4. I understand that my participation in the discussion is voluntary, and that I can stop participation at any time without consequence. I can decline to answer any question without penalty.
5. I understand that if I feel upset after taking part in the interview I may take part in the free counselling provided for this purpose by referral in collaboration with the GBVRC/TCC.
6. I understand how the information I give at this discussion will be used.
7. I have received an Information Sheet with contact details of the researcher in case I would like further information about the project.

Do you consent to participate in this discussion? ☐ Yes ☐ No

_____ _____

Name of Research Participant Signature: Participant

_____ Date _____

APPENDIX G

QUANTITATIVE DATA COLLECTION GUIDE

RESEARCH SITE: **DATE:** **LOCATION:**	
DESCRIPTION	**QUANTITY**
A. Prevention	
1. Number of community awareness forums/education campaigns conducted in the last 12 months (including other prevention activities)	
2. Number of prevention activities conducted in collaboration with other organizations/agencies that work on collaboration in the last 12 months 3. Number of community awareness forums/education campaigns conducted in the last 12 months (including other prevention activities)	
4. Number of victims referred to economic empowerment programs from the research site in the last 12 months	
B. Protection	
5. Number of trainings of police/ healthcare workers/community leaders conducted in the last 12 months (on how to respond and handle a sexual violence victim)	
6. Number of services (types) provided on site/ through referral	
7. Number of victims reporting reoccurrence in the last 12 months	
8. How of time it takes for victim to receive services needed on site	
C. Prosecution	
9. Number of cases received in the last 12 months	
10. Percentage of cases supported that were investigated and got to prosecution stage, in the last 12 months	
11. Percentage of cases received that were prosecuted to completion	
12. Number of trainings/ collaborative trainings for police and prosecutors in the last 12 months	
D. Punishment	
13. Number of sexual violence cases supported that resulted in conviction	
14. Number of victims who have participated in any victim impact assessment pre or post-trial in the last 12 months	

15. Number of victims who sought other options other than criminal prosecution of perpetrator	
16. Number of sentences which deviated from minimum sentencing requirement	
E. Redress	
17. Number of victims who sought recourse other than prosecution	
18. Number of convictions	
19. Number of victims who accessed other remedy they chose (e.g. Number of successful compensation civil suits; depending on what comes up at the research sites).	

APPENDIX H

INTERVIEWEES DETAILS AND DESCRIPTIONS

KENYA		
SERVICE PROVIDERS INTERVIEWED		
CENTER	**PARTICIPANT**	**Number**
Nairobi Women's GVRC (Urban, Private)	Legal Officer	1
	Counselling Psychologist	2
	Social worker	1
	Program manager for response	1
	Program manager for prevention	1
	Police surgeon (Affiliated to centre)	1
	Case manager	1
	Clinical officer	1
Total		**9**
KNH GBVRC (Urban, Tertiary)	Legal aid officer	1
	Social worker from affiliated shelter	1
	Forensic Nurse	1
	Centre's social worker	1
	Police officer	1
		5
PGH Nakuru GBVRC (Provincial)	Forensic nurse	1
	Social worker	1
	Medical Officer	1
	Police officer	1
	Paralegal	1
		5
Kitale GRC (Rural)	Key informant: funder from supporting NGO	1
	Social worker	1
	Trauma counsellor	1
	Nurses	2
	Clinical officer	1
	Police officers	2
	Children's officer 2 (affiliated to center)	2
		10
Total		**29**
FOCUS GROUP WITH VICTIMS		
CENTER	Participants in group interview	
Nairobi Women's GVRC		12
Kitale District GRC		12
Nakuru PGH GBVRC		6
KNH GBVRC		6
Total		**36**
SOUTH AFRICA		
Karl Bremer TCC (Urban, District)	Forensic doctor	1
	Social worker	1
	Site coordinator	1
	Police officers	2
	Psychologist	1

	Victim assistant officer	1
	Counsellor	1
	Nurse	1
	Case manager	
Total		**9**
Heideveld TCC (Urban, District)	Counsellor	1
	Forensic medical officer	1
	Nurse	1
	Victim assistant officer	1
	Site Coordinator	1
		5
Worcester TCC (Provincial)	Site coordinator	1
	Police officer	1
	Case manager	1
	Medical Officer	1
	Counsellors	2
	Social worker	1
	Nurse in charge of casualty department	1
		8
Wesfleur TCC (Rural)		
	Lead counsellor	1
	Counsellors	2
	Victim assistant officer	1
	Police officer	1
	Social worker	1
	Forensic Doctor	1
	Forensic social worker	1
	Site coordinator	1
	Special sexual offences prosecutor	1
Total		**10**
S.A total (service providers)		**32**
Other key informants (K.I) interviewed in South Africa		
K.I at National Prosecuting Authority		**1**
K.I at the regional management of TCCs		**2**
KI at Department of social development		**1**
Total in SA		**36**

Description of some Interviewees roles

- Case Managers in the TCCs are legal officers hired by the South Africa's NPA as one of the TCC staff, they are based in the courts and their role is to be the link between TCCs and the courts
- Victim assistant officers (VAO) are TCC staff hired by NPA, with a social work background their role is to follow up cases and are the link between the TCCs and the victims
- Site Coordinators at TCC staff hired by the NPA to oversee and manage the collaboration of all sectors and integration of services through the TCC
- Where I indicate simply 'nurse' these are general nurses who different from any other with special descriptors such as 'forensic nurse' at the centres
- Case managers in Kenya's GBVRCs play different role, they are not lawyers, often social workers or counsellors who play the role of following up cases, much like the TCCs VAOs.